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# Addressing the elderly as audience: the ethical responsibilities of writers and companies

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**Addressing the elderly as audience: The ethical  
responsibilities of writers and companies**

by

**Patricia Ann Allen**

**A thesis submitted to the graduate faculty  
in partial fulfillment of the requirements for the degree of  
MASTER OF ARTS**

**Major: English (Rhetoric, Composition and Professional Communication)**

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**2001**

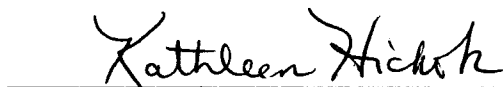
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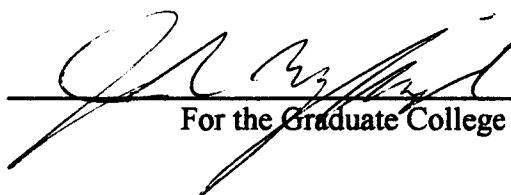
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I dedicate this thesis to Ben, who supports and encourages me in everything I do. I also dedicate it to Jess and Greg and thank them for their unwavering confidence in Mom.

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## ABSTRACT

The elderly population, one of the fastest growing age groups in the United States, is an audience that technical writers have not addressed. To argue the importance of addressing the elderly as audience, this thesis poses three research questions: How do elderly individuals read and respond to documents they are typically expected to use? How can technical communicators write and design documents for the elderly, and why should they be concerned with this audience? What ethical responsibilities do both writers and their companies have to make information more accessible to the elderly audience? A literature review of technical communications and other disciplines indicates that changes often do occur with aging—changes that could impact reading and comprehension.

To test that impact, 16 healthy, active elderly subjects, aged 65 to 90, were asked to answer questions from two Medicare supplemental insurance policies. Data were obtained from pre- and post-test interviews, transcripts of think-aloud protocols, and observations. Based upon the results of the testing, guidelines are listed for technical communicators to follow when writing and designing documents for the elderly audience. Additional research is suggested to further expand the list of guidelines. Demographic information on the growing number of elderly supports the importance of studying this population.

Finally, a review of stockholder, stakeholder, or social responsibility theories of business ethics shows that each theory can be used to argue that writers and their companies have an ethical responsibility to the elderly. Logical, economical, and ethical arguments are given for why technical writers can and should recognize the elderly as an important audience for many of their documents.

## CHAPTER 1: CONSIDERATION OF THE ELDERLY AS AUDIENCE

*When Mimi greeted me at her door, I could almost feel her energy. She smiled, laughed, talked a lot, and made me feel very welcome in her home. My first question to her—asking about her activities—confirmed my sense of her energy. Mimi calls herself a “jack of all trades.” She talked about her love of reading, gardening, knitting, and refinishing furniture. I found her easy to believe when she said, “I may not do it well, but I will tackle most anything.” Mimi is a 72 year-old woman in relatively good health. She admits to high blood pressure; but laughingly says that the problem is probably caused by the fact that her husband is retired and around the house more. She and her husband take several trips a year and also travel to see their children in California, Massachusetts, Kentucky, and Iowa. Mimi finds time to do volunteer work and to participate in a Bible class at her church. Before retirement several years ago, she worked first as an optometry assistant and then a dental assistant. Mimi and her husband both frequently mentioned several of their friends with whom they interact often; and they were even instrumental in referring me to some of those friends for potential participants.*

*Both Mimi and her husband admitted that Mimi is the one who actually takes care of all of the insurance and Medicare paperwork. She participated in the testing for me and did not seem to feel rushed or to become frustrated with the documents. She admitted that one of the policies I asked her to test was from the same company and a very similar policy to the Medigap policy she and her husband have. Despite her familiarity with at least one of the policies and despite the fact that she handles all of the insurance matters in her family, Mimi was only able to correctly answer one of the six sets of questions based on these documents.*

The questions Mimi tried to answer about two different Medicare supplemental insurance policies are typical of questions that owners of such policies might ask. Mimi was also fairly typical of the participants who agreed to take part in my document testing. The way Mimi and the other elderly participants approach these documents and the kind of assumptions they make about them are important for technical writers to know. And, if this healthy, active older person has problems using Medicare beneficiary documents, how will other less-educated, more marginalized elderly manage?

In this chapter, I present research questions about writing for the elderly as well as discuss reasons for looking at this particular growing segment of the population. I begin by briefly reviewing three major rhetorical theories and examining the ways in which each theory places importance on some type of audience analysis when writing and designing text. If we accept the importance of audience to technical communicators, regardless of which theoretical perspective we take, we next must ask whether we can group the elderly together as a particular audience. Since little research exists in the field of technical communication about the elderly, I look to other disciplines for guidance—gerontology, cognitive psychology, and human factors. Based upon the research from these three fields, I determine what changes occur as people age that might allow us to make some generalizations.<sup>1</sup> Next, given that the research and theories strongly support the importance of audience and that physical and mental changes in the elderly make them a distinct audience, I look to the code of ethics for technical communicators for any discussion of the ethical responsibilities of technical communicators to an elderly audience. And, finally, I review three frequently mentioned theories of business ethics to guide my discussion about the ethical responsibilities of companies and their writers as they design documents appropriate for elderly audiences.

### **The Research Questions**

The 2000 census reveals that the population in the United States was 281,421,906 on April 1, 2000 (U.S. Census Bureau 2000). The 2000 census also shows that

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<sup>1</sup> In this research project I look at the elderly as a single audience. I am aware that we could separate the elderly into different audiences based upon factors such as age, education, health, and socioeconomic status.

34,991,753 members of that population in the United States are 65 years of age or older—14,409,625 are males and 20,582,128 are females. Approximately one in every eight persons in the United States is over the age of 65. As an employee in the health care industry over the past few years, I am aware that the health care industry has taken note of and is trying to plan for the growth in this population segment, but are others doing the same thing?

Technical communicators do not appear to be as concerned about this large elderly population that is and will be, in growing numbers, the readers and users of the documents they design. A review of the literature about writing and designing documents in technical communication reveals very little consideration of the elderly as audience. In pursuing this issue, I identify four concerns that must be addressed in order to lay the necessary groundwork for my investigation of elderly readers as a critical audience:

- ◆ Theoretical perspectives that establish the importance of audience to writers
- ◆ Discussions about mental and physical changes in the elderly in the literature of gerontology, cognitive psychology, human factors research, and technical communication
- ◆ Code of ethics for technical communicators that might be applied to the ethics of writing for the elderly
- ◆ Theories of business ethics

All four of these concerns are addressed in the literature review in which I show that audience is important to writers, that mental and physical changes do occur in the elderly that make them a distinct audience, and that ethical standards and theories

recognize the importance of this group. This literature review makes a strong case for technical communicators attending to the elderly segment of the population as a distinct audience.

While a number of disciplines consider the elderly a definable audience, technical communication exhibits a remarkable lack of concern for or reference to writing for the elderly population. This lack of concern has become the guiding force for my research questions:

1. How do elderly individuals read and respond to documents they are typically expected to use?
2. How can technical communicators write and design documents for the elderly, and why should they be concerned with this audience?
3. What ethical responsibilities do both writers and their companies have to make information more accessible to the elderly audience?

To answer my first research question of “How do elderly individuals read and respond to documents typical of those elderly readers are expected to use,” I designed and conducted my own research and testing project. As I explain in more detail in chapter two, I tested 16 participants, who are 65 years old and older, as they looked for specific information within two very differently designed Medicare supplemental insurance (Medigap) policies. This information then leads to a discussion of my second research question : “How can technical communicators write and design documents for the elderly and why should they be concerned with this audience?” I develop suggestions about style and design that then lead to a discussion of my third research question: “What ethical responsibilities do both writers and their companies have to make information more

accessible to the elderly audience?" To address this third research question, I review theories in business ethics that are relevant to ethical and legal responsibilities technical communicators and their companies should consider in addressing an elderly audience. However, before addressing my three research questions, I want to use my review of literature to argue that technical communicators should be studying the elderly.

### **The Rationale**

By the year 2025, at least one in five individuals (and perhaps some of you reading this thesis) will be over the age of 65, and "...these older people will be healthier physically and psychologically, will be legally entitled to work beyond age 65 if they wish, and indeed will be needed in continued employment to support the economy" (Powell 1994, 201). Currently, the group of adults 55 years and older "owns 77 percent of all the financial assets in America,...[and] spends more on [such things as] health and personal care than any other age group..." (Joyce 1994, 341).

This growing segment of the population is buying computers, VCRs, programmable telephones, and other technical equipment. They are seeking information from Web sites. They are reading instructions and safety warnings at job sites. As we learn from those who participated in this project, they are taking classes, volunteering with young people, traveling, reading, and even writing and publishing books. In short, these elderly are an audience for many of the materials written by technical and professional writers. Given that the elderly are a large segment of the audience for the material we write and that they will continue to grow in numbers and, perhaps, in influence, logically,

technical communicators must address this population. However, this population has particular needs that are not as critical for younger adult audiences.

### **Review of the Literature**

The census data clearly establish that the population over 65 is growing and that this population will increasingly be users of documents written and designed by technical communicators. As writers, we might ask, “What does the literature in our discipline say about the audience?” And, “If the elderly are the audience for our texts, what can we learn from various disciplines about this audience?” And finally, “What, according to the literature, are the ethical responsibilities of technical communicators and companies to this audience?”

**Review of Perspectives about Audience in Rhetoric.** As I have suggested, the importance of audience has long been a topic for much discussion and research in technical and professional communication. “A thorough analysis of our audience’s prior knowledge, attitudes, and needs, as a means toward designing and developing appropriate texts” (Duin 1989, 100) is a necessary step for the technical communicator. A strong theoretical base exists to support the importance of audience to technical communication. Several of the major theoretical approaches in the discipline have focused on how audiences interpret texts and “how readers go about ‘constructing’ meaning and the constructive strategies they use to do so” (Haas and Flower 1988, 171). A brief review of just three of those approaches—cognitivist, social constructionist, and externalist—that



address the importance of audience gives us an understanding of what contributions rhetoric can bring to an attempt to accommodate the elderly as audience.

*Cognitivist Theory.* One theoretical perspective in rhetoric focuses on cognitive processes. Cognitivists argue that writers can learn a process—a generalizable, codifiable process—for conveying information as effectively as possible to a reader (Kroll 1984, 176). A structure underlies the process of writing and reading and, according to cognitivists, we can isolate and codify that structure—the cognitive processes.

For these theorists, to know an audience is to understand those cognitive processes that members of an audience use to interpret a text. Cognitivists would argue that a text is “...readable to the extent that its meaning can be easily and quickly comprehended for an intended purpose by an intended reader operating under normal conditions of alertness, motivation, time pressure, etc.” (Huckin 1983, 91). According to cognitive theory, writers must determine just what the cognitive processes of the elderly are and whether these differ in any way from those of other audiences. We must also determine what the “normal conditions” are under which most elderly read and comprehend. Cognitivists would suggest that we can determine those conditions for the elderly audience (if we accept that they can be grouped as an audience), find out what cognitive processes they use for understanding information, teach what we have learned, and use this information in designing documents for the elderly.

*Social Constructionists.* A second theoretical perspective in rhetoric takes a social view. Social constructionists state that “human language (including writing) can be

understood only from the perspective of a society rather than a single individual” (Faigley 1986, 535). A reader’s interpretation of a text occurs within the social context, the discourse communities, in which he/she exists (Kent 1993; Kroll 1984); and “writing only becomes comprehensible...within a framework of either shared mental states or shared social conventions” (Kent 1993, 85). Knowing and understanding the discourse communities to which audiences/readers are a part means knowing “...many of their community values and their shared background knowledge, as well as the conventions of discourse they accept...” (Fulkerson 1990, 417).

Social constructionists then must look at the shared discourse communities and shared background knowledge of the elderly. To determine how to address the elderly as audience, social constructionists must establish which community values and discourse conventions are more acceptable to this audience. They must look at the generational values of the elderly and determine how physical changes, social status changes, and life changes impact the ways in which the elderly look at and process information. So social constructionists would argue that we can learn about the elderly as audience (again, if we accept that they can be grouped as an audience) by understanding their social context: their discourse communities, shared knowledge and conventions, generational values, and life changes. Writers must develop this understanding to be able to write and design documents appropriately for the elderly.

*Externalists.* A third theoretical perspective in rhetoric centers on individual idiosyncratic interpretation. Externalists believe that no internal framework “mediates between us and the world” (Kent 1993, 86). A writer/speaker and listener/reader can only

employ guesses in producing or understanding communication. These guesses are called passing theories. Participants come to a communication with their own passing theories and must adjust or readjust those theories as they communicate (either orally or through written text). “All we possess are our tentative passing theories or hermeneutic guesses...that allow us to relate our meaningful marks and noises to the meaningful marks and noises of others” (Kent 1993, 88).

Externalists are interested in determining the background knowledge (knowledge of conventions, schema, discourse communities, etc.) of the elderly to help writers produce an adequate passing theory—a better hermeneutic guess. Despite the fact that according to the externalist theory no exact framework or specific social context can guide us in writing for any group, the more writers know about the audience and interact with the audience, the more likely writers will be to come close to the audience’s passing theory and to successfully communicate with that audience.

Admittedly, the role that audience plays in communication differs in each of these approaches, but each approach emphasizes the importance of some level of understanding or some knowledge of the audience. The main “...point is that, no matter which view of textual adaptation to audience one takes, all such views imply the importance of ‘audience’ to the writing” (Fulkerson 1990, 416). By placing audience in such a prominent position, these theories all provide a motive for addressing the elderly as audience. These well-known and frequently supported approaches to rhetorical strategies should be the driving force behind an attempt to understand the implications for writing when the audience is elderly.

If we accept, then, that knowing and understanding our audience as much as we can is important, the next obvious issue is whether or not we can group the elderly together. Do people over the age of 65 approach reading and comprehension in similar enough ways to be considered a particular audience based solely on their age? Since rhetoricians and technical and professional communicators have generally not addressed this issue of the elderly as audience, I looked to other disciplines to help answer this question, and I found research that suggests that certain changes often occur in the elderly population that might impact the ways they process information.

**Research on Physical and Mental Changes in the Elderly.** To determine whether or not we can group the elderly together as an audience, we need to look at what changes often occur with aging and whether those changes might affect reading and comprehension. The vast majority of the research, books, and journal articles on changes in the elderly<sup>2</sup> can be found in three major fields of study: gerontology, cognitive psychology, and human factors study. Each field looks at the aging process from a different perspective, but all rely on much of the same data. I reviewed research in these fields in order to gain an understanding of the knowledge base that is available from which technical and professional writers might draw. I also looked at the sparse information that is available in technical and professional writing.

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<sup>2</sup> Some disagreement and debate exists in the literature about how to define the elderly (see Powell 1994; Blanchard-Fields and Chen 1996; and Browning 1995). Many researchers were "...just as impressed by the growing variability among...subjects as they grew older as...with the decline in average cognitive functions" (Powell 1994, 206). Based upon the research in gerontology, cognitive psychology and human factors, we may not have the definitive answers about why changes occur, and we may not be able to predict when changes will occur for any one individual, but we can predict that many physical, sensory, and cognitive changes do occur for much of the population over 65 years of age.

*Gerontology.* Gerontologists have been interested in the physical and cognitive changes that the elderly experience and the effects of those changes on education and learning. These researchers continue to study the cognitive effects of short-term memory loss and working-memory capacity on the elderly (Browning 1995; Light and Anderson 1985; Bolton 1978; Bennett and Eklund 1983; Glendenning and Stuart-Hamilton 1995; Jones and Bayen 1998). For example, Light and Anderson designed experiments in which young and older adults were given a series of reading and recall tasks designed to measure working memory capacity and memory for paragraphs. Their evidence suggests that working memory "...plays an important role in discourse processing" and that a significant change in the elderly occurs with tasks requiring "...simultaneous storage and manipulation of information in working memory" (1985, 737).

Most researchers in gerontology are also looking beyond cognitive processes for possible functional and psychological factors that influence learning in the elderly. Studies of factors such as motivation, loss of speed, physical health, and education may lead to a better understanding of so-called age-related changes (Bolton 1978; Glendenning and Stuart-Hamilton 1995; and Bennett and Eklund 1983). For example, one study discusses how vision changes that occur in the elderly might affect performance and "...how intellectual performance may be improved by attempting to compensate for vision loss" (Bennett and Eklund 1983, 435). Unfortunately, many studies relating age to learning ability use tasks that are meaningless, trivial, and irrelevant or uninteresting to the

elderly, which suggests that the results would be impacted by a lack of motivation.<sup>3</sup>

Considering motivation as an important factor would support the idea that

“...performance and ability to learn in old age...depend not only upon physical and mental capacities, but upon willingness to use these capacities fully” (Bennett and Eklund 1983, 272).<sup>4</sup> Also, when other physical aspects such as speed of performance are an issue, the elderly often perform at a lower level because of a noted general loss of speed rather than because of impaired learning abilities.

Some gerontologists support the theory that the elderly at some point may experience some short-term memory loss and working-memory capacity decrease that might affect reading and comprehension. But, more important, these researchers in gerontology seem to be saying that, rather than simply looking at mental changes, we need to consider the physical changes, such as changes in vision, in general health, and in speed and reaction time. Many of these physical changes can affect how thoroughly the elderly process information (e.g., blurred vision can obviously hinder reading and comprehension). Also these researchers suggest that we should consider the changes in motivation for learning or understanding that might come with aging. Understanding what motivates most elderly to learn could be important to understanding how to design and write information for them.

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<sup>3</sup> The tasks I chose for participants for my thesis were designed to be of importance to the elderly audience. Most people over the age of 65 are concerned with health care coverage, which makes Medigap policies valid test documents for this group.

<sup>4</sup> These authors also point to loneliness as an important factor in motivation. Those elderly who interact less frequently with others are often less motivated to learn or understand textual information. In the interviews for my study I asked questions to determine if the participants regularly interact with family and/or others.

Jones and Bayen (1998, 680-81), an educator and a psychologist who are interested in identifying older adults' instructional needs, present a list of recommendations for teachers who teach the elderly to use computers. I have selected those recommendations that apply to printed documents and categorized them, based upon a review of the research on physical and mental changes in the elderly, into three factors:

#### Contextual factors

- ◆ Allow more time for reading.
- ◆ Rely on recognition rather than cued recall.
- ◆ Use language explicitly without requiring the older adult to make "subtle inferences" (681).

#### Organizational factors

- ◆ Use advance organizers.
- ◆ Chunk material "...into discrete units with specific goals" to "...reduce the amount of cognitive processing resources required by older adults" (681).
- ◆ Relate new information to prior knowledge when possible.

#### Design factors

- ◆ Provide information with pictures or figures as well as text to decrease the demands on working memory.
- ◆ Select font sizes that are easy to read.

The goal of most of the research in gerontology is to discover the best methods for teaching older students. Many of those same methods will be helpful to technical

communicators in writing effectively for the elderly audience. But a look at other disciplines is also helpful.

*Cognitive Psychology.* Work in the field of psychology about changes in the elderly has focused predominantly on memory loss and reduction in the ability to process information (a decrease in working memory) in the aged (J. Hartley 1988; Zacks and Hasher 1988; A. Hartley 1992; and Cohen 1988). Kramer and Larish review research findings that show significant age-related differences exist in the performance of dual tasks—performing two tasks concurrently. They discuss several studies that find that “...older subjects are more penalized when they must divide their attention, either between two input sources, input and holding, or holding and responding” (1996, 84-5). One proposal is that these dual tasks, as well as single tasks that are complex, require more resources. Resources would include “...working memory capacity,<sup>5</sup> attentional or mental energy, and the rate of performing different mental operations” (1996, 86). The studies cited do show some decrease in these resources during aging.

Another study, conducted by Morrell and Park, was concerned with the decrease in working memory of the elderly and specifically looked at procedural tasks. Their hypothesis was that “...adding illustrations to instructional text may lessen age-related performance differences by minimizing processing demands on working memory in the elderly” (1993, 389). The study had younger and older participants construct 3-

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<sup>5</sup> Jones and Bayen (1998, 679) state that “working memory is a system for the short-term storage and simultaneous processing of information ‘during the performance of a range of cognitive tasks such as comprehension, learning, and reasoning.’” They suggest that the elderly perform more poorly in complex tasks.



dimensional objects from three types of instructions (text only, illustration only, or text and illustrations together). According to their results, adding illustrations to text reduces errors,<sup>6</sup> which suggests a decrease in the demand on working memory.

Other studies, such as those of psychologists Kemper (1988) and Light and Anderson (1985), looked at the relationship of language and language processing to decreased working memory in the elderly. Research shows that "...linguistic skills deteriorate in old age in otherwise healthy and active adults" (Kemper 1988, 58). Kemper's study provides evidence that the elderly have some difficulty producing and processing sentences with embedded clauses, especially a left-branching constructed clause.<sup>7</sup> She tested a group of elderly and a group of younger adults. Their task required them to hold sentence prompts in memory long enough to detect and correct a grammatical error. The prompts included both a main clause and an embedded clause. The older adults (ages 70 to 80 years) incorrectly imitated the sentences with embedded clauses 52 percent of the time. The younger adults (ages 30 to 49 years) incorrectly imitated the sentences with embedded clauses only 12 percent of the time (Kemper 1988, 62).

Research in psychology on aging changes is still emerging, providing other theories to be studied (such as linking language acquisition with language dissolution).

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<sup>6</sup> Actually, their results showed that errors were reduced in both the younger and older group, but an age-related variance still remained.

<sup>7</sup> A left-branching constructed clause is one in which the embedded clause interrupts the main clause. Left-branching structures are assumed to be more difficult to produce and comprehend because the main clause constituents must be anticipated while the embedded clause is being produced or processed. Kemper (1988, 61) gives an example of a left-branching relative clause: "The news that Bill left the party without his coat upset John."

Much of the more current research in psychology supports the presence of cognitive changes with advancing age (Powell 1994; Detweiler, Hess, and Ellis 1996), but psychologists (like gerontologists) are also beginning to look to the effects of other factors (such as emotion and physical health) to explain cognitive and performance changes in the elderly. A body of research exists that places cognitive functioning within a social context:

An individual's life tasks (e.g., goals, social roles) and social knowledge are shaped by life experience and values specific to a particular generation, cultural expectations, and changing life stages (e.g., parenting stage, stage in career). In turn, social knowledge and life tasks influence social information processing (i.e., perceptions of situations and others, past memories for events) and cognitive strategies.... In other words, contextual variables play a significant role, not only in the content of social knowledge and life tasks but also in their accessibility and impact on cognitive strategies performed in one's everyday context. (Blanchard-Fields and Chen 1996, 232)

No matter which causal factors are proven, the research findings in the field of psychology are definitely relevant to technical and professional communicators as they write for the elderly as their audience: the problem with complex single or dual tasks, the decrease in working memory and attentional energy, the slowing of mental operations, the deterioration of linguistic skills, and the difficulty in processing sentences with embedded clauses. All of these factors, together with the idea that cognitive functioning occurs within a social context, should be taken into account when deciding how to design and write documents to be used by the elderly audience. But technical communicators can learn even more about changes in the elderly and the implications of those changes from another discipline.

*Human Factors Study.* Human factors study is an area with strong interests in the changes that take place as humans age. Human factors (sometimes called ergonomics, engineering psychology, or human engineering) is a "...discipline with a strong performance orientation, with its central theme being how to design products or processes to enable someone to do a task more efficiently and safely" (Charness and Bosman 1992, 495). In the human factors literature reviewed for this study, some of the authors (Czaja 1990; Charness and Bosman 1992; and Park 1992) analyze the available research about physical and cognitive changes in the elderly and suggest ways to adapt the environment to accommodate those changes. For example, designs for automobiles, street signs, markers, warnings, and lighting can be altered in ways to accommodate the aging changes in visual acuity, contrast sensitivity, light perception, field of vision, strength, and response time. So far, human factors' designs can only be guidelines because the empirical bases for those designs are still weak. Most of the theories and recommendations from this discipline are based upon research carried out in other disciplines (such as gerontology and psychology).

Despite the fact that little original research on changes in the elderly has actually been done by human factors researchers, writers can still learn much from this discipline. This group has taken the existing research and applied it very practically (e.g., an understanding of vision changes has led to changes in size, shape, color and locations of signage). While expecting technical communicators to become human factors experts is unreasonable, we can expect them to "attend to human factors and to become knowledgeable about sources of human factors expertise" (Clement 1987, 155). Writers can follow the lead of human factors researchers and apply the current research on aging

changes very practically to writing and design techniques. But have technical communicators looked at the research about the elderly and applied that research to writing?

*Technical and Professional Communication.* Moving from these three disciplines to technical and professional communication, I found that little information is available in technical and professional communication literature about writing for the elderly. In an article about writing instructions for the elderly, Van Hees (1996, 522) admits “...communicators largely lack the knowledge on how to write and design instructional texts for an elderly audience.” Van Hees looks very carefully at many different studies in gerontology (e.g., studies about how elderly readers process text and studies about changes in cognitive processes and physical abilities). He uses these studies as a basis for analyzing where the elderly have problems using and understanding technical manuals and using hard copy manuals for programming or installing on a technical product (such as a VCR or a computer). Van Hees did no user testing. Based upon the research data from some of these gerontological studies, Van Hees comes to several conclusions about why the elderly have problems using manuals. From these conclusions he develops five tips about what the content, structure, and language of instructions should look like:

1. Avoid sentences with embedded clauses or relative clauses as much as possible. This kind of sentence seems to be apt to cause confusion in elderly readers specifically.
2. Restrict the need for making inferences in general and the need for assigning antecedents to pronouns in particular. Elderly people are less apt to fill in implicit information than younger people, and even if they do make the inference, they are more apt to do this incorrectly.
3. Use explicit statements as to the location of buttons and levers on the

product, or name typical features (such as color, size, or form) of these buttons or levers. This helps elderly people to locate the item searched for more quickly.

4. Explicitly encourage older users to test whether their actions have been correct and have the right effects. Feedback usually enhances the task performance of elderly people.
5. Be careful in presenting analogies to make the manual content more clear. They might impede text usability for an elderly user instead of improve it.

Van Hees (1996, 532) also gives a list of five tips about how to better design documents for the elderly:

1. Use a letter font with an x-height of 6 to 9 mm.
2. Be careful to use a letter type with heavy contrast. Do not use light ink colors for the type, and do not use dark paper for printing. Elderly readers often have difficulty in discerning visual stimuli that do not contrast sharply to their background.
3. If you want to use different colors for distinctions between different kinds of information, do NOT use a combination of green and blue, green and red, or different light pastel colors.
4. Use line drawings with little fine spatial detail for illustrations in manuals. Details such as shadowing do not enhance understanding of pictorial information in elderly users, and can often cause confusion. Avoid dotted lines, which ask for reconstruction of the line as a whole.
5. Depict the product in a three-dimensional way. For reasons that are not clear yet, this seems to be the way of depiction that elderly expect.

Van Hees admits that making conclusions on the usability of texts based upon results of gerontological studies that are seldom focused on instructional texts is at best tentative. He suggests that testing the elderly with the think-aloud research method (which I did in collecting data for this thesis) would be productive. He notes that "this method does not seem to pose specific problems for elderly subjects...[and that] think-aloud research must offer other interesting insights, for example, into the opinions of the elderly on...products and...instructional texts" (1996, 533).

Van Hees recognizes the need for technical communicators to carry out their own research and testing of the elderly as an audience. The rhetorical theory points to the

importance of understanding audience in whatever way possible. The disciplines of gerontology, cognitive psychology, and human factors support the idea that we can look at the elderly as a group. Given these facts, what ethical responsibilities do writers have to address this audience?

**The Ethical Responsibility of a Technical Communicator.** Ethics within the field of technical communication is a topic of more and more interest in the literature. Dragga (1996) suggests that the tough issues have not yet been fully debated and discussed. We find little guidance in the code of ethics statements of the Society for Technical Communicators (see Wegner 1993), which tells what a technical communicator should do:

- ◆ Recognize his/her responsibility to communicate technical information truthfully, clearly, and economically.
- ◆ Use language and visuals with precision.
- ◆ Prefer a simple, direct expression of ideas.
- ◆ Satisfy the audience's need for information.
- ◆ Hold him/herself responsible for how well the audience understands the information.
- ◆ Be committed to professional excellence and ethical behavior.

To follow this code, writers must be committed to ethical behavior, which means they must at least "satisfy the audience's need for information." Dragga (1996, 30) argues that the notion of ethics is somewhat buried in that code despite the fact that the "...ability

to design information gives the technical communicator a new rhetorical power and imposes new ethical obligations on using that power.” How we choose to write and design a document powerfully impacts the way the audience processes (or does not process) the information in that document.

The statement within the code of ethics says that writers should hold themselves responsible for how well their audience understands the information; this issue is also of concern to plain language advocates. The federal government mandates that government writers use plain language when writing or rewriting federal regulations. The plain language approach addresses writers’ responsibilities to readers:

The recipients of communication must have access to information necessary for understanding, and the information must be in language they can comprehend. The originators of communication [e.g., technical writers] must respect the recipients as people worthy of an honest message and assume accountability for the truth of that message. (Crow 1988, 92)

So the questions are how can writers respond ethically to the needs of the elderly for information, and how can writers meet their obligations to their clients (their employers) at the same time they meet their obligations to the audience? Writers are often constrained by their employers. So does the ultimate responsibility for ethical and responsible writing remain with the individual or the corporation? After all, “the writer works in the company’s building, breathes the company’s culture and takes home the company’s paycheck” (Crow 1988, 91). Who is responsible for making information more accessible to the older user, such as 72-year-old Mimi? To prepare for some discussion about a company’s ethical responsibilities to write for the elderly, I have reviewed some of the literature about business ethics.

**An Understanding of Business Ethics.** The topic of business ethics is a complex one—and one that seems to elicit much debate. As I reviewed some of the literature about business ethics, I began to really appreciate its complexity. While many of us in technical communication probably have some thoughts or opinions about business ethics—what might and might not be ethical and what a writer’s role in ethics should be—few in the discipline appear to have used business ethics as the basis for analyzing or recommending changes to documents.<sup>8</sup> To look at what ethical responsibilities companies have in writing for the elderly, I want to do two things: develop some understanding of the debate about the nature of business ethics and discuss ways in which writing for the elderly is a factor in business ethics.

Understanding business ethics actually means understanding the debate that exists about the place for ethics within companies. The debate about the role of ethics in business falls on a continuum from arguments that ethics has no role and should not be considered in business all the way to the argument that only those companies that always make decisions that are morally right can be considered ethical.

At one end of the spectrum is the stockholder theory. Some (Carr [1968] 1999; Friedman [1970] 1995) argue that businesses and business executives are responsible only to their stockholders. In a much-quoted article from 1970, Friedman says that the “social responsibility of business is to increase profits” (76). Carr, in another well-known article on ethics from 1968, somewhat similarly argues that, while ethical considerations are not

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<sup>8</sup> Some technical communicators, for example, Bryan (1992), Dragga (1996), Clark (1987), and Girill (1987), are exceptions and have explored issues of ethics in technical communication. Further, *Technical Communication* has a column about applied ethics for writers. But the research in other disciplines such as business has received little attention in the teaching or practice of technical communication.



irrelevant to corporations, they simply are not as important to a company as profitability and growth. He suggests that decisions made in the competitive business world are decisions of strategy, not decisions of ethics. Carr ([1970] 1989) suggests that “When the directors and managers of a corporation enter the boardroom to debate policy, they park their private consciences outside” (28). He even suggests that if the businessman does not make his own scruples second place to the corporation’s growth and increase in profit, that businessman is failing his responsibility. A business and its managers must make decisions that lead to increased profit and, thus, benefit the business’s stockholders—to whom that business is ethically responsible. But, that is not to say, even within this theory, that there is never a place for ethics:

Whatever ideas he [the ethically motivated executive] advocates to express his sense of social responsibility must be shaped to the company’s interests. Asking management flatly to place social values ahead of profits would be foolhardy, but if he can demonstrate that, on the basis of long-range profitability, the concept of corporate efficiency needs to be broadened to include social values, he may be able to make his point without injury—indeed without benefit—to his status in the company.... He must show convincingly a net advantage for the corporation in accelerating expenditures or accepting other costs in the sphere of social responsibility. (Carr [1970] 1989, 29)

Further along the continuum, others would argue that companies have an ethical responsibility to all their stakeholders and that “stakeholder is not synonymous with shareholder” (Clarkson 1995, 112). This view holds that a company’s social, ethical and economic responsibility lies with all its primary stakeholders: stockholders, employees, customers, suppliers, and the local community. All of a company’s decisions should be made with some consideration of all of the primary stakeholders. And when the interests between one group and another conflict, a business has to balance those interests as much as possible. When increasing profits (for the good of the stockholder) means decreasing

the quality of the product (which impacts the customer) or decreasing wages (which impacts the employee), ethically the business executive must find a way to balance those interests. When companies "...define and accept responsibilities and obligations to primary stakeholders...they have entered the domain of moral principles and ethical performance" (Clarkson 1995, 112).

At the other end of the continuum then are those who support the idea that a company should act ethically simply for ethical reasons, that "...social responsibility is supported for its own sake because that is the noble way for corporations to behave" (Mintzberg 1989, 164). Companies should act ethically and morally because it is the right thing to do—for the good of all. Actually, this idea appears to have been modified by some who suggest that it is in the best interest of companies to be socially and ethically responsible—that it is a sound investment. The arguments are that socially responsible businesses help create a better society and "...a better society produces a better environment for business" (Mintzberg 1989, 165).

This review summarizes just three approaches to business ethics that appear frequently in the literature. We can use one of these approaches, or some combination of these approaches, to determine what would be considered ethical behavior or to argue the responsibility of companies to act ethically. Since the elderly may be members of the stockholders, or of any of the other stakeholders, and are certainly important members of society, then writing for the elderly is a business ethics issue.

After I present my methodology, research data, and analyses in the next two chapters, in the fourth chapter I demonstrate how writing appropriately for the elderly can be shown to be the right thing for companies to do no matter which of these or other

theories of business ethics that is argued. Through the information presented in the next three chapters, I answer my three research questions:

1. How do elderly individuals read and respond to documents they are typically expected to use?
2. How can technical communicators write and design documents for the elderly, and why should they be concerned with this audience?
3. What ethical responsibilities do both writers and their companies have to make information more accessible to the elderly audience?

In the final chapter I discuss what I hope to be the implications of this study and identify some future research topics I hope will be investigated by technical communicators.

## CHAPTER 2: TESTING HOW THE ELDERLY USERS READ AND RESPOND TO DOCUMENTS

*I met up with Fanwell (his chosen pseudonym) at the entrance to the local public library, a place where he can often be found. We scheduled our meeting for ten o'clock in the morning because he starts his day a little later since he retired almost 25 years ago (the year of this country's bicentennial). Although we have only talked over the telephone and have never been introduced, I knew that I would recognize him—almost everyone in our small community is familiar with him. Fanwell, since his retirement, has written and published four books. Two are genealogies, and two are historical works about our community. He frequently writes editorials about various topics for the local newspaper. Before retirement, Fanwell's work involved writing narrative appraisals of properties for the highway department. He spoke with pride of the over 2,000 narratives that he wrote in that job. His statements confirm his continuing love of writing: "I write things that are sometimes not even written for publication. I just write them because I want to make a record."*

*Fanwell is 90 years old, walks with a cane for safety and support, carries a briefcase stuffed with information, and lights up when given a chance to talk about his interests. He continues to live with his wife and takes care of all of the details of their daily lives. He recently had a physical and was told by the doctor that "everything is great." A decrease in vision in one eye affects him somewhat—slows down his reading and causes him to scan more instead of reading entire articles.*

*Despite his college education, his command of words, and his knowledge of writing, Fanwell was only able to answer two out of six of the questions he looked for in the two documents that he tested for me. Like some of the others, he blamed himself, not the documents, for his inability to find the answers: "I'm not finding an answer, but it's probably a reflection on me.... Well, maybe now I'm the one that is flunking."*

Because the fastest growing segment of our population today are those over 85 years of age (Infanti), Fanwell and others like him are an important audience that will be using the documents that technical communicators write. As the average life expectancy (which now is in the 70s, depending upon ethnicity and gender) continues to increase, the elderly become a more important group to study. And, based on additional census data

The data from these tests can become a catalyst for further studies that would increase our knowledge about how to write and design documents for the elderly.

I considered the three basic techniques of testing completed documents as I designed my study: *text-based testing*, *expert-based testing*, and *reader-based testing*. *Text-based testing* “usually concentrates on the words and sentences of a document” and examines “local-level features of a document and then draws conclusions about factors such as the document’s reading level and use of language” (Burnett 2001, 428-29). Text-based methods include such methods as readability formulas, computer analyses, and guidelines (Schrivier 1989, 241). I am, of course, interested in the language of these documents; but, more important, I am interested in the responses of people like Fanwell, Mimi, and others to the language and design (as well as other aspects) of the documents. One weakness in the text-based methods of testing is that they focus on word- or sentence-level features and “...their output provides no information about the reader’s needs” (Schrivier 1989, 244).

*Expert-based testing* focuses on the accuracy and inclusiveness of the documents. This may include peer review, technical expert review, or editorial review. Most readers probably would assume that an insurance policy from a reputable firm is carefully expert tested by persons with both legal and insurance knowledge. Schrivier argues that, while these expert evaluations are very useful to the writer, the evaluators are often too close to the text and/or the product. “The result is that the text may work well for...people who developed or influenced the creation of the text—but may fail miserably for the average reader” (1989, 247).

*Reader-based testing* provides information about the document “from readers as they read and use a document...or after they have finished reading it” (Burnett 2001, 430). Reader-based testing often identifies problems within a document that expert-based testing and text-based testing do not identify (Burnett 1994, 48). We not only get information about the ways in which the audience responds to the text, but we also get more reaction to the text at both the global and local levels.

Two issues of potential concern exist with reader-based testing: Cost and time require us to limit usability tests to only a few users, and the testing is sometimes done in an artificial setting. Testing a large number of users is both impractical and unnecessary. In this project I tested 16 people aged 65 and older. Five to 15 test subjects is typical for think-aloud reader-based testing. Tests can be very useful if we choose subjects that “accurately represent the real users” (Redish and Schell 1989, 70) and if we choose tasks that are appropriate for the document. The quality of the data that I collected from these 16 elderly people using these techniques supports the idea that “we compensate for the paucity of subjects by the richness of the data we collect” (Redish and Schell 1989, 70).

I compensated for the artificiality of the testing in three ways. First, I used documents (Medigap policies) that are of interest to most elderly people 65 years old and older. Second, I tested all but two<sup>9</sup> of the participants in their homes—usually a more relaxed and realistic setting than a laboratory or office. Home is where people would probably actually use these documents. And, third, all of the participants used in this

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<sup>9</sup> As I stated at the beginning of this chapter, Fanwell was tested at the local library. Another participant, John, asked that I meet him near a classroom in a public building where he was taking a “Class for Seniors.” Both settings were familiar and comfortable for these participants.

project except Sydney have a supplemental policy of some kind, which verifies the importance of these documents to them.

Despite these potential problems of reader-based testing, this type of testing provides the most pertinent information when the target audience is the elderly. I considered other methods of gathering data about ways the elderly use these documents, but I decided that I would not find the answers I am looking for using these other methods. For example, I considered gathering information by surveying elderly policyholders about the legibility of their Medigap documents. I suspected (and confirmed with participant interviews) that at least the owners of Medigap policies participating in these tests rarely refer to their policies for information. The majority of the participants I tested admitted that they are more confident relying on third parties (usually physician office personnel or hospital personnel) to determine what is and is not covered by their policies. As a result, since this group of policyholders does not really look for answers in their policies, a survey would not address the usability of the documents. Also, completing a survey requires the elderly participants to recall rather than recognize information. As explained in chapter one of this thesis, studies of short- and long-term memory changes suggest that the elderly tend to have some difficulty with recall tasks and perform better with recognition tasks.

In addition, I considered looking at the problems and concerns that elderly people call in with on their Medigap policies to determine the usability of these documents. However, the information from calls to help lines would not tell me much about how well the elderly find information in their Medigap policies if they call in without first trying to find the answers on their own, as suggested by the elderly participants I interviewed.

I decided that only reader-based testing would give me information about how the elderly actually use and react to these documents. To gather as much data as possible, I used three different types of reader-based testing:

- ◆ **Think-aloud testing:** The participants were asked to say aloud their thoughts and reactions as they actually used the documents in trying to answer some questions. Participants were asked to say whatever came into their thoughts or to read aloud any headings, words, or sections in the documents that they paid particular attention to. All the comments were tape recorded and transcribed. (See Appendix A for transcripts of the 16 participants.)
- ◆ **Observation:** I observed all the participants as they used the documents and noted how long they took to complete the tasks (if they, in fact, were able to complete them), how they actually maneuvered through the documents (any particularly difficult or easy sections), and how they reacted to the documents overall (did the reader seem comfortable using the documents or seem frustrated). My observations and notes have been transcribed in appropriate places in the transcripts. (See Appendix A also for the observation notes.)
- ◆ **Pre- and post-test questions:** Before the testing, I asked the participants several questions to determine their general health status and level of independence and to get some idea of how they function mentally and physically. After each test, I also asked the participants follow-up questions to get their overall reactions to the documents. (The pre- and post-test questions asked and the responses given can also be found in Appendix A.)



The following sections discuss in greater detail the choice of the documents, the methods for selecting test participants, and the actual testing strategies: the problems presented, the observation and tape recording techniques, and the interview questions asked before and after the testing. This chapter ends with an explanation of my plan to analyze the data extracted from these tests.

### **The Test Documents**

For my study, I selected test documents that would actually be used by people over 65 years of age. Medigap policies are designed to cover some expenses not covered by Medicare. Because Medicare requires deductibles and coinsurance, some people purchase Medigap insurance to help fill that “gap” in the Medicare coverage. Medicare is a federal government health coverage program, but only private companies offer Medigap policies. Because of problems early in the program of sales representatives convincing elderly people to buy several different Medigap policies, when only one would cover expenses, the government mandated that Medigap policies be standardized and that only ten different varieties be sold.<sup>10</sup> These plans are identified by the letters A through J, and a company does not have to sell all ten plans. Insurance companies are not allowed to modify the standardized benefits in any way. Figure 1 contains information from *Iowa's Guide to Medicare Supplement Insurance*. This information lists the ten plans and the benefits offered in each plan.

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<sup>10</sup> This is true in all states except for Minnesota, Massachusetts, and Wisconsin. HCFA granted these three states waivers and allowed them to structure their policies differently. All three states offer basic benefits but are allowed to alter options.

## Supplementing Medicare

Medicare supplement insurance is also called "Medigap" or "MedSup." It is private insurance designed to fill gaps in Medicare coverage and is sold by many companies. It is not sold by the government. Those eligible for employer-provided insurance, HMOs or Medicaid assisted programs usually do not need Medicare supplement insurance.

**Only ONE Medicare supplement policy is needed!**

Since January 1, 1992, insurance companies selling Medicare supplement policies in Iowa are limited to selling 10 "Standardized Plans." The plans are identified by the letters A through J. A company does not have to sell all 10 plans, but every Medicare supplement company must sell "Plan A" (Basic Benefits only). The other nine plans have Basic Benefits plus different combinations of additional benefits. **An insurance company cannot add to or modify the benefits in any way.**

Companies must continue to honor policies purchased prior to January 1, 1992. You **DO NOT** have to drop a policy purchased before that date.

Ten Standard Medicare Supplement Plans										
Basic Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Part A Hospital										
Day 61-90 Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Day 91-150 Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
365 More days - 100%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance-20%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Parts A & B Blood	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Additional Benefits	A	B	C	D	E	F	G	H	I	J
Skilled Nursing Facility Coinsurance Day 21-100			✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Deductible			✓			✓				✓
Part B Excess						100%	80%		100%	100%
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Basic Prescription Drugs								✓	✓	
Extended Prescription Drugs										✓
Preventive Medical Care					✓					✓

**Figure 1.** Ten different types of Medigap policies are available. (Source: *Iowa's Guide to Medicare supplement insurance*, Senior Health Insurance Information Program, 2000.)

Since Medigap policies are public documents and are written primarily for the elderly, these documents are appropriate artifacts for analysis. The companies that offer

these plans must offer the same benefits, but these companies are not required to design their policies in the same way—as long as the benefits they offer conform to one of the ten standard policies. However, the Medicare Supplement Insurance Minimum Standards Model Act (Act) of 1995 does dictate that an outline of the coverage offered by a Medigap policy must be delivered to the applicant when application is made. According to the Act, the state commissioner

...shall prescribe the format and content of the outline of coverage.... For purposes of this section, “format” means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. (NAIC 2000, 650-4)

So while the Act mandates that an outline be provided at the time of application, mandates how that outline must be formatted, and mandates what coverage each policy must provide, the Act does not mandate how the actual policy is written and designed.

Companies that produce Medicare beneficiary publications are “asked” to follow some audience specific guidelines.<sup>11</sup> I received an e-mail message from Kris Gross, director of the Senior Health Insurance Information Program in Iowa, in response to my request for information on laws and regulations related to how Medigap policies must be written and designed. Her reply was that “...the only thing that is specified is the print size for some of the **information** [emphasis mine] that is given.... That’s it. There is nothing required as far as readability or plain English” (Gross 2000). Because the textual and design features of each company’s documents are not actually dictated and can be very different,

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<sup>11</sup> Company B in this project (and perhaps others) do make an attempt to accommodate the elderly audience by following these Medicare requested guidelines (e.g., use of 14-point serif font in text other than headings; minimal use of italics, glossy paper, thin paper or newsprint, and reverse printing; use of high-contrast paper and lettering; sensitivity to color blindness; and written at a grade level no high than 7<sup>th</sup> or 8<sup>th</sup>).

but the content must be the same, these documents make good study instruments for this project.

In order for the content to be exactly the same for both documents that I used, I tested the participants using Plan F policies of Company A and Company B (see Appendix B for copies of these policies). Company A and Company B are large, national, third-party insurers. Both enjoy a generally positive reputation among both the customers and providers and are perceived as interested in improving services. In order to preserve their anonymity, I refer to them as Company A and Company B throughout.

I chose the plans from these two companies because they were the only companies, of the five companies that I contacted, willing to provide me with copies of their policies.

Despite the fact that these policies are public documents, many companies (or at least the employees that I spoke with at those companies) are unwilling to provide copies of the policies to someone not interested in actually purchasing or eligible to purchase a plan. I considered obtaining copies of policies already held by elderly friends and acquaintances to use as samples, but I wanted to make sure I had the most current printing of the policies (in case the writing or design changed from printing to printing). Since I only received policies from two companies, I cannot attest to how other companies have designed their Medigap policy documents and how appropriate those designs are for an elderly audience.

Both Company A and Company B offered only some of the ten standardized plans that can be offered. I chose Plan F because, of the plans offered by these two companies, this plan offers more coverage and allows a greater variety of questions to be presented to the participants. Table 1 gives a detailed summary of the design differences between the

**Table 1.** A comparison is made of textual and design features of Company A and Company B policies.

Company A	Company B
<ul style="list-style-type: none"> <li>◆ 10-point font</li> <li>◆ Sans -font</li> <li>◆ Minimal white space with dense text</li> <li>◆ Lines are right justified</li> <li>◆ All paper document</li> <li>◆ No advance organizers</li> <li>◆ Sections are continuous on the pages</li> <li>◆ Table of contents embedded in the middle of the first page</li> <li>◆ Table of contents lists all major and subheadings</li> <li>◆ Bolds all headings and subheadings and all terms listed in the definitions whenever those terms appear in the policy (e.g. you, your, we, Medicare, etc.)</li> <li>◆ Section on <i>Definitions</i> is included on page 3 and defines 14 terms</li> <li>◆ Lists points under each section as 1, 2, 3, etc. and subpoints as a, b, c, etc.</li> </ul>	<ul style="list-style-type: none"> <li>◆ 14-point font</li> <li>◆ Serif font</li> <li>◆ Extra white space throughout</li> <li>◆ Lines are ragged right</li> <li>◆ Stiff cardstock front and back covers</li> <li>◆ Advance organizers each section</li> <li>◆ Each new section begins on a different page</li> <li>◆ Table of contents is the only text on the second page</li> <li>◆ Table of contents lists all major and only a few subheadings</li> <li>◆ Bolds headings, subheadings and all information in advance organizers. Also bolds first words in bulleted lists.</li> <li>◆ <i>Glossary</i> is the last section of the policy and defines 22 terms</li> <li>◆ Has mainly running text with a few bulleted lists</li> </ul>

two documents. The Plan F policies for Company A and Company B do contain exactly the same benefits, but they are written and designed quite differently. For example, as noted, Company A's policy uses a 10-point sans-serif font, denser text with little white space, and numbered lists. Company B's policy uses a 14-point serif font, extra white space, and bulleted points.

### **The Participants**

In order for the testing to be effective, the participants needed to be both physically and mentally capable of completing the tests. A list of all of the participants (using only the code names that they chose), along with some information about each one, is presented in Table 2. My plan was to select the participants based upon several criteria.

**Participant Criteria.** The participants used in the testing are all 65 years old or older. They range in age from 65 to 90. Other factors were also considered in selecting the participants to test: age, gender, health status, independence, and physical and mental activity levels.

The first two criteria, age and gender, are important for determining if any differences in performance exist based upon those two factors. While this thesis is concerned with the elderly as a group, I separated the participants into two age groups to determine differences in response. Eight of the participants are between 65 and 74 years old, and the other eight are 75 years old or older. The elderly are often distinguished in research articles as the *young-old* (those aged between 65 and 74 years of age) and the

**Table 2.** Code names and characteristics of test participants are listed.

Code Name	Age	Gender	Education Level
Sydney	66	Female	College degree
Kay	69	Female	High school diploma
Pansy	69	Female	High school diploma
Mimi	72	Female	High school diploma plus two years of college
Flossie	74	Female	College degree
April	76	Female	High school diploma
Louise	79	Female	High school diploma plus one year of college
Dee Dee	89	Female	High school diploma
John	66	Male	Ph.D. degree
Alley	73	Male	College degree
Charles	74	Male	College degree plus some post-graduate work
Vic	75	Male	Ph.D. degree
Bottle	75	Male	Ph.D. degree
Dutch	76	Male	College degree
Punjab	79	Male	College degree
Fanwell	90	Male	College degree

*old- old* (those over the age of 75).<sup>12</sup> Half of the participants are male and half are female, again, to identify any correlation between gender and test performance.

Other important information was sought from each participant to reveal to some extent how each functions mentally. Determining participants' levels of interaction with other people, participation in stimulating activities, and awareness of the world around them, gives some indication of their potential abilities. I did not want to subject the participants to a reading comprehension pretest that might tire them out before completing the actual testing for this research, so I relied upon the information sought from the

<sup>12</sup> Bernice Neugarten, a prominent gerontologist, was the first of many to use these two age distinctions.

participants to reveal how they function. In my work as a registered nurse for over 18 years, one of my primary professional responsibilities was always to evaluate how patients function physically and mentally, based primarily upon information obtained from patient interviews and from observations. I feel confident that, guided by the answers from the seven groups of questions, I was able to get a good understanding of the level of functioning of each participant. Figure 2 shows the complete list of pre-test questions that I asked the participants.

<b>Pre-Test Questions</b>	
1.	What are your hobbies? Do you travel? Read? Play cards? Exercise regularly? Do volunteer work and, if so, what kind?
2.	Do you read the newspaper daily or watch TV regularly? What kind of shows?
3.	Are you a member of and active in any clubs or organizations or do you serve on any committees (such as church committees)?
4.	Do you work? What kind of work? If retired, what did you do before you retired? Do you stay connected to your former profession in any way?
5.	Do you prefer large print books or magazines? Do you have any problems with subtitles or scores on TV? Have you had eye surgery? Do you have cataracts, glaucoma, or macular degeneration?
6.	Do you live alone? Do you have family close by? Do you still drive?
7.	How would you describe your general health? What specific chronic health problems do you have, if any? What if any, medications do you take regularly?

**Figure 2.** Pre-test questions were asked to determine each participant's health and physical status.

The first four groups of questions give a good indication of how much these participants interact with other people and are aware of what goes on in the world around



them. Those elderly who are involved and are active physically and mentally are more likely to be functioning better mentally. The Gerontology Center at Pennsylvania State University is studying the potential of training to improve memory, concentration, and problem-solving skills in the elderly. The hypothesis currently being tested, and the notion held by some gerontologists, is that the “use it or lose it” motto for physical development may also apply to memory and thinking (Infanti). The answers to the first four questions indicate whether or not these participants are “exercising” their minds by participating in activities and interacting with people.

The fifth group of questions is designed to determine the visual abilities of the participants. While I would expect some changes in vision for many people after the age of 65,<sup>13</sup> I wanted to make sure that the participants would be able to read both documents. Even though the documents use different font sizes and a participant might prefer one over the other or find one easier to read, I verified that each participant could in fact read each policy. As a Certified Registered Nurse in Ophthalmology, I knew that I would be able to assess the participants’ visual acuity with questions.

The sixth group of questions gives an additional indication of activity and, more important, support. As mentioned in chapter one, motivation is potentially an important factor in how the elderly perform. An older person who does not interact much with others and has little contact with family is likely to be lonely and loneliness can certainly impact motivation. While not a guarantee, having family close by or being in frequent contact with family would suggest an elderly person has support and family interaction.

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<sup>13</sup> According to Bennett and Eklund (1983, 256), some 95 percent of adults by the age of 65 have some alteration in lens transparency, leading to progressively blurred vision.

The seventh and last group of questions was meant to reveal any health problems or medications that might affect participants' cognitive abilities. Again, as a registered nurse, I am aware of, or able to determine, the potential impact of many disease processes and medications on physical as well as mental functioning.

These seven groups of questions were asked of all participants before they took part in the testing. Follow-up questions were asked as needed to clarify answers or to obtain more information when necessary. All of the information combined allowed me a brief look at how each of these 16 participants functions. The participant descriptions at the beginning of each chapter are included to capture some of the rich portraits that came out during these initial discussions.

**Participant Selection.** Because I was concerned that some elderly people might be suspicious of talking with me about insurance policies—for fear that I was actually working for the insurance companies—I decided that being referred to potential participants would be preferable. Although I had only met one of the participants before the testing, all of the participants were either given my name by someone they knew or were referred to me by someone they knew. I was able to meet with and test all but two of the participants in the comfort of their homes. In some cases, after the testing was finished, the participant suggested other possible participants and made referrals for me.

This method of selection seemed to result in an immediate sense of trust because participants knew that I had tested a friend or friends of theirs.<sup>14</sup> The participants were

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<sup>14</sup> I tested three sets of married couples. In each case, I tested first one, while the other was out of the room; and then I tested the second one, while the first was out of the room.

comfortable with me coming into their homes or meeting with me and comfortable talking with me about themselves. I think this resulted in much more effective testing and more information than I might have gotten had I approached strangers randomly with no prior introduction.

### **The Testing Strategy**

The basic testing strategy was to present each of the participants with questions to answer from information in each document. To more fairly test the usability of the two documents, I alternated which document was used first, and I also alternated which questions were asked with each document. Table 3 gives a listing of the order of the documents and questions presented to each participant. Alternating which document was used first by a participant controlled for a participant's increasing comfort with the process after the first few questions and controlled for any learning factor carried over from the first to the second document. The participants looked for information based upon three scenarios with questions that they were given for each document. The two groups of three scenarios were alternated with each document, thereby controlling for differences in the degree of difficulty in the problems presented. (Figure 3 gives a listing of all six question sets.)

The research project and testing procedures were explained to the participants using the consent form, which was approved by Iowa State University's Human Subjects Committee (see Appendix C for copies of the Human Subjects Research approval form and the consent form). Each person I tested and interviewed signed the form, consenting

**Table 3.** The order of the documents and questions was alternated with the participants.

Participants	Document Order	Question Order
Kay	Policy A Policy B	Questions ABC Questions DEF
Charles	Policy A Policy B	Questions ABC Questions DEF
Vic	Policy A Policy B	Questions ABC Questions DEF
April	Policy A Policy B	Questions ABC Questions DEF
Pansy	Policy B Policy A	Questions ABC Questions DEF
Flossie	Policy B Policy A	Questions ABC Questions DEF
Bottle	Policy B Policy A	Questions ABC Questions DEF
Sydney	Policy B Policy A	Questions ABC Questions DEF
John	Policy A Policy B	Questions DEF Questions ABC
Dee Dee	Policy A Policy B	Questions DEF Questions ABC
Dutch	Policy A Policy B	Questions DEF Questions ABC
Louise	Policy A Policy B	Questions DEF Questions ABC
Mimi	Policy B Policy A	Questions DEF Questions ABC
Alley	Policy B Policy A	Questions DEF Questions ABC
Punjab	Policy B Policy A	Questions DEF Questions ABC
Fanwell	Policy B Policy A	Questions DEF Questions ABC

- Question A:** Suppose you are traveling in Italy for 30 days, become sick, and require an emergency appendectomy. Is it covered? Who covers it? How much is covered?
- Question B:** How do you file a claim with this company for a visit to the doctor's office?
- Question C:** Once you have this policy, can the company ever increase the premium charges? If so, when can they change them?
- Question D:** Who pays the Medicare deductible for Medicare part A? What about Medicare part B?
- Question E:** Suppose you were in an automobile accident and were seriously injured. After 10 days in the hospital, your doctor decides you need to have 3 months (120 days) of skilled nursing care in a place approved by Medicare. As you may know, Medicare covers all expenses for the first 20 days. How does this policy help you with the remaining skilled nursing care costs?
- Question F:** Does this policy help pay for your doctor's office visits? If so, how does it help?

**Figure 3.** Six problem scenarios were presented to each participant to solve.

to participation in the tests, to being tape recorded during the think-aloud process, and to being interviewed. I gave a copy of the consent form, along with my name and telephone number, to each participant in case he or she had any questions or concerns later on. During the testing, participants were asked to think aloud and read aloud as they proceeded through the documents answering the questions. To encourage the participants to talk freely and to admit to any difficulty in understanding or finding information, I emphasized that I was testing the documents, not the users. Only Pansy seemed somewhat anxious and concerned about how long she was taking during the test. Throughout the testing, I continued to encourage the participants to think and read aloud so I could follow their process.

After each document was tested, I asked questions about any reactions to the document. These questions were asked to elicit the participant's subjective reaction to and observations of that policy. I basically asked each person to give me his or her opinion about the documents and to tell me what was good and not so good about each policy or to suggest how the document might be improved. After completing both tests, the participants were asked to compare the two documents. And, finally, I asked all the participants if they have a Medigap policy and if they ever refer to the policy. This information would often be revealed at some time during the pre-test interview or during the testing, and so I would not ask it again during the post-test questioning. In the case of the three married couples, often only one of the spouses would be familiar with their supplemental policies.

### **Analyzing the Data**

The observations, the tape recordings, and the post-test questionnaires provided me with considerable data about how these elderly participants used the test documents. The transcriptions of the tapes, together with my observations, allowed me to determine in some cases where in the documents anyone had obvious difficulty either understanding the text or locating the pertinent information. The post-test questions provided even more information from the participants to verify the observations and transcripts.

**Observations.** As each one of the elderly participants moved through the tests, I observed and noted their reactions to the documents, which proved an important source of research data. I collected both quantitative as well as qualitative data. The quantitative

data includes the amount of time each person spent attempting to answer each question and the accuracy of their answers. Responses were only considered accurate when they were answered completely. All of this data allow me to look for any correlation between correct responses and the time the participants took to make that response. The quantitative data includes the time the participants took answering or trying to answer the questions. Comparisons are made then from document to document and from task to task to determine any correlation. I also looked for any differences in correctness of response and length of time for responses between any males and females. I divided all of the participants into two age groups: the young-old (65 to 74 years old) and the old-old (75 years old and older) and compared responses and times based upon age. And, finally, I looked for any differences based upon level of education of the participants.

As I observed the participants, I gathered information about how the participants were using the documents by noting

- ◆ Where in the documents the participants seemed to move easily and where they hesitated
- ◆ When the participants moved through to the same information over and over as they searched for answers to the problems
- ◆ Whether the participants referred to the table of contents or the list of definitions in either of the documents
- ◆ What design features the participants used to guide them through the documents.

Also, based upon my experience as a nurse assessing patients, I noted participants' overall reactions to the documents and/or the tests. I was able to judge when participants were frustrated, embarrassed, or confused.

**Tape Recordings.** The tape recordings of the participants as they worked to answer the questions provided information about some of their thought processes as they maneuvered through the documents. The results naturally varied from person to person. Some participants were much more comfortable thinking and talking aloud than others were. Some participants, even with frequent encouragement, did little thinking or talking aloud. For those participants I had to rely more on my observations. During the testing I noted the point in each document where specific negative or positive comments were made and then compared my observations with transcripts of the tape recordings. I looked for patterns that would suggest problem points in the texts or positive aspects of the textual features by noting participants' reactions:

- ◆ Comments that they do not understand the text
- ◆ Statements suggesting that they would like more information or a definition
- ◆ Evidence of participants rereading a section, a sentence, or even a clause
- ◆ Comments that they understand but then give the wrong information
- ◆ Specific mention of headings as they read through the documents
- ◆ Comments about other design features within the texts (such as bolding or bulleted lists)



- ◆ Comments about the tables of content, either their effectiveness or ineffectiveness.

**Post-test Interviews.** And, finally, I obtained information from the post-test interviews. The questions were asked to elicit the participants' subjective reactions to the documents. I looked for a correlation between how well they completed the tasks for each document and their subjective responses to those documents. I asked participants if they had a Medigap policy and whether they look to it for information. Their answers provide information about ways that this type of document is actually used in everyday situations. This information, along with comments made during the document testing, also often gave me an idea about each participant's familiarity with terminology and processes involved with using these Medigap policies.

Analyzing all of this data allowed me to determine to some degree what textual and design elements of each document worked well for the elderly audience and what textual and design elements were a problem for this audience. In the next chapter, I look in more detail at a number of problems with the documents that were experienced by more than one participant. I present some examples from the interviews and observations that show the impact of these problems, and I discuss some of the implications and possible solutions.

The information collected from these tests provided answers for my first research question: How do elderly individuals read and respond to documents they are typically expected to use? The data allowed me to begin to understand how the elderly approach a document and to see whether an elderly audience-specific approach to using documents

exists. This information then leads to the answer to my second research question: How can technical communicators write and design documents for the elderly and why should they be concerned with this audience? The data allows me to begin the discussion of how documents should be written and designed for an elderly audience. This information should also lead to my third research question about the ethical responsibilities of technical communicators and their companies and should lend support to my argument that writers, and companies that they write for, are ethically responsible to make the effort (through interviews or reader-based tests) for understanding their elderly audience's needs and for designing documents accordingly.

In the next chapter, I discuss all of the data I obtained from this research methodology. I analyze the data and look for patterns that might indicate ways in which these elderly users approach finding information within documents.

### CHAPTER 3: ANALYSES OF THE ELDERLY PARTICIPANTS' RESPONSES TO THE TESTS

*Alley is almost three-quarters of a century old—an age we often avoid thinking about. He is a handsome, slim man, and his thick snow white hair is the only clue to suggest his age. He is not the stereotypical picture most of us have of a 73 year old. He lives alone, still mourning the loss of his wife over a decade ago and, also, the loss of his companion dog less than a year ago. Alley retired around 1990 from his long-time job as a design engineer for the federal government. He says he follows what is happening in his former profession, but he is not actively involved with engineering. Alley travels frequently for extended visits with his children and grandchildren in Florida and Colorado. His children often try to convince him to move close by. He admits that he is reluctant to leave his home, community, and friends; and that he is content with his extended visits with family for now. One of Alley's favorite past times is helping students at the local high school with woodworking projects. And, until the death of his dog, he could be spotted all over town walking his dog miles from his home. He also loves to read. He described the book he had just completed and strongly urged me to read it.*

*Alley agreed to participate in my study and invited me to his home for the testing. I looked with envy at his everything-in-its-place rooms as I entered his house—apparently the home of a very meticulous, organized man. To my surprise, this educated, active, healthy engineer had some difficulty with the tests, as he missed four out of six of the questions. His actions and comments suggested frustration even with one of the questions he was able to answer correctly because he felt it took him so long to find the information: "I should have spotted that immediately, you know. Right there on the top line...that should really have told me—additional benefits—it should have."*

Alley, although perhaps more energetic than some of the participants, was overall fairly typical of the 16 participants in my research project. From the many books and articles that I read for this project, I am convinced that all of these participants are fairly typical of much of the elderly population. A recent article in *The Des Moines Register* (Recer 2001) reveals that a new study from the National Academy of Sciences shows that the elderly in the U.S. are "more vigorous" than ever before. The study reports that "fewer people over 65 require nursing home care and more are living on their own, with little or no outside help." Works about baby boomers and the new aging suggest that the

“...theory of ‘successful aging’ is not just a theory. ...On any given day in America, of all our population over 65, 81% are doing more than OK physically. ...They are independent and fully functional” (Levine 2000, 72). This statistical and anecdotal evidence provides strong support for researching the elderly, as has been done in this project.

A more detailed look at Mimi, Fanwell, Alley, and all of the other 16 participants is presented in this chapter. I also look at possible correlations between age, gender, or education level and participants’ success in answering questions correctly. I review the responses of all of the participants to each of my six usability questions and focus on several issues:

- ◆ The successes of the participants in answering the questions
- ◆ The differences in performances when groups were separated by different characteristics (e.g., gender, age, and education level)
- ◆ Any design or textual elements that seem to hinder or help participants when searching for this information in these two documents.

As I look more in depth at some of the textual and design features that hindered and/or aided the participants as they used these documents, I present quotes from and observations of the participants describing these features.

All of this information contributes to an understanding about the ways these 16 elderly participants reacted to and used the test documents and provides some answers to my first research question: How do elderly individuals read and respond to documents they are typically expected to use? Those clues begin to help us answer my second

research question: How can technical communicators write and design documents for the elderly? I offer some suggestions to companies and their designers/writers as to how they might use this information.

### **The Participants**

The elderly participating in the testing of the two Medigap policies are evenly divided by gender—eight are male and eight are female. They are also divided by age: eight are under the age of 75 years (the young-old) and eight are 75 years of age or older (the old-old).<sup>15</sup> All of the participants in this study live in or around the small university community of Ames, Iowa.

Although I did not ask any of the participants particular questions during the testing to reveal their level of education, in general conversation I learned that this group on average is very well educated. Three of the participants hold a doctoral degree, and two others have some post-graduate education. Five of the participants have a college degree, and three have one or two years of post-secondary education. And three participants have a high-school diploma. Many of the participants were in professional fields: three were university professors, three were professional engineers, one was an optometrist, two were nurses, one had been a highway appraiser, and one participant formerly worked as a dental assistant. Of the other five, three did not work outside the home, one was a factory worker for several years, and one did secretarial work.

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<sup>15</sup> The age groups in this study were not evenly divided between women and men. The 65-to-74-year-old group consisted of five women and three men, and the older group was the reverse.

Based upon the interview questions concerning health status and activity level and based upon my knowledge as a registered nurse evaluating patients, I found all of the participants to be very capable and competent mentally and, for the most part, to be functioning very well physically. They all are actively engaged in some way with different groups (e.g., clubs, church committees, golf groups, classes, etc.). Without exception, this group keeps up with the news by reading at least one newspaper (and sometimes two) a day and watching the news on television. And they keep mentally active in other ways. For example, John participates in courses offered for seniors at the university in Ames. Ninety-year-old Fanwell spends a lot of his time researching and writing and is recognized as the local historian. All of the participants are active, interesting people.

Four of the participants are somewhat affected physically by health conditions. Two (Sydney and Pansy) are physically limited by chronic breathing problems, and two (Flossie and Dutch) are actively involved in a cardiac rehabilitation exercise program following heart surgeries (claiming to be the first husband-and-wife team to go through cardiac rehabilitation together).

Because of the varying size of the print of the two documents, I was interested in the vision of each of the participants. Only two of the participants (Fanwell and Louise) have any significant visual problems—both revealing retinal changes in one eye. While they are both able to read the text of the two policies, each one did miss four out of the six questions asked, but neither of them complained about print size. Fatigue or strain from working harder to read the information could potentially have played a role in the number of their incorrect responses.

Based partially upon what the information reveals and partially upon just my observations of these participants, I am categorizing these 16 elderly participants as independent and very active. Overall, they are fairly healthy or are controlling their health problems sufficiently. They are, without exception, vigorous and appear to be capable of managing their own affairs.

### **The Quantitative Testing Results**

In this section, I discuss what the data tell us about possible correlations between policy differences, gender differences, or age differences and the ways the participants responded. I also look for any correlation between education level and the participants' performances. And, finally, I measure the time on task for each group and look for any differences in time on task from policy A to policy B and from group to group.

**Policy Responses.** I asked each of the 16 participants three usability questions for each policy—a total of 96 questions. Of the 96 questions, 53 questions (or 55 percent) were answered correctly, and 43 questions (or 45 percent) were answered incorrectly or incompletely. The incorrect and incomplete responses were basically evenly divided between the two policies: 51 percent were from policy A and 49 percent were from policy B. These results indicate that, despite the distinct differences in the design and textual features of the policies, the inaccessibility of information appeared to be the same for these participants. Furthermore, no differences were apparent due to the order in which the questions were asked. Table 4 shows how each of the participants did on the tests when separated by gender, age, and education level.

**Table 4.** Incorrect response rates are given based on participant characteristics.

	<b>% Incorrect Responses Both Policies</b>	<b>% Incorrect in Policy A</b>	<b>% Incorrect in Policy B</b>
<b>All responses</b>	45	48	42
<b>Males</b>	42	37	46
<b>Females</b>	48	58	37
<b>Ages 65-74</b>	37	46	29
<b>Ages 75 &amp; up</b>	52	50	54
<b>College &amp; Graduate Degrees</b>	40	37	38
<b>High School</b>	61	50	56

**The Gender Issue.** I looked at error rates based on gender to see if any correlation exists between gender and error rate and also to see if any difference exists in the way the two groups performed with each of the two policies. The eight males participating in the testing had a 42 percent error rate. The eight females had a 48 percent error rate. For the male participants, 45 percent of their errors were from policy A and 55 percent from policy B. For the female participants, 56 percent of their errors were from policy A and 44 percent from policy B. As indicated in Table 4, males did slightly better overall in the tests. I questioned whether, perhaps, more of the males that I tested handled insurance matters than did the females. In reviewing the conversations and the information, I discovered that while six out of eight of the males either lived alone (and thus handled their own insurance matters) or were the spouse who took charge of these matters, six out of eight of the females also either lived alone or were the spouse in charge



of insurance claims. These data suggest that familiarity with insurance matters does not play a role—although the fact that a person is the one in charge of his/her insurance claims does not necessarily mean that he/she does any more than allow third parties to take care of matters.

Education is another factor, discussed in greater detail in a later section of this chapter, that could account for the difference in performance between males and females. As Table 4 shows, those with higher education levels did better on the tests than those with only high-school diplomas (and in some case one or two years of college). All of the males interviewed and tested in this project have at least a college degree, and three of the male participants each have a Ph.D. degree.

The percentages do show that the male participants performed better when using policy A, and females performed notably better when using policy B. A review of policy B shows design features (such as large serif font, greater chunking of information, and an increase in white space) that would suggest that the writer was concerned about legibility. In contrast to the legible design in policy B, policy A, as described in chapter two, uses a very dense, small sans-serif font. As suggested by these examples of remarks made by participants during the post-test interviews, many of the females preferred policy B:

April [comparing the two policies]: “I liked this one [policy B] better, frankly. It was just easier to see.... It was much simpler for me.... The other [policy A], you have to read through a lot of stuff to find out what you’re looking for. This one [policy B] is simplified—or it was to me.”

Flossie [in her last post-test interview]: “Overall, I liked that one [policy B] much better than this one [policy A]—easier to read, easier to understand, easier to find.”

Sidney [giving her consistently negative reaction to policy A]: “[Policy A] is closely typed, and people are going to say, ‘I’m not reading that. If they don’t cover it, they don’t cover it.’ You know...what they’ll do is they’ll take it in when they go to the doctor or they go to the hospital and say, ‘Here’s my policy, does it cover everything I need?’ I don’t think they’ll look at it because it is not set up for them to understand.”

One possible explanation for the male participants’ apparent preference for policy A may be somewhat connected to the fact that five of the eight males were either engineering professors or practicing engineers. Perhaps they are accustomed to reading text designed this way. Or their preference for policy A might be connected to their perception of what insurance policies look like. Kostelnick and Roberts (1998) note that when we look at a document, “we bring our stored knowledge to that perceptual moment.” And, because of prior encounters and traditions with certain genre, “...our perception of documents actually begins before our eyes even meet the page” (1998, 50). Policy A has the more traditional look of an insurance policy, as these representative remarks from the post-test interviews point out. Despite the fact that both policies contain essentially the same information, two of the engineers thought policy A contained more information, even though, by law, the content of the policies is identical:

Alley [comparing the documents in the post-test interview]: “...it just seemed like this one [policy A] was a little more detailed.... While that one [policy B] is easier to read and it jumps out at you more, if I had my choice I would still take this one [policy A]. I...like the in-depth.”

Vic [in his post-test interview comments]: “This one [policy B] is easier to read, but it is not as complete.”

**The Age Factor.** Age apparently did play a role in the participants’ results. The 75-years-and-above age group had more incorrect and incomplete responses than the

younger age group. The older group was responsible for 58 percent of all of the errors. They missed 52 percent of the total questions they were asked—or one out of every two questions.

I investigated the possibility that fatigue was a factor for the older group. I looked to see whether the older group committed more errors or gave up on finding answers more frequently as they moved through the questions. I found that their errors were fairly evenly divided: the 75-years-and-above group committed 52 percent of their errors on the first three questions that they were asked and 48 percent of their errors on the last three questions—regardless of which set of questions was asked first. So these figures suggest that fatigue was not the cause of the older group committing more errors than the younger group. I would suggest that the reason for the difference is that the 75-and-above group is older and has probably experienced more aging changes, that the age-related physical and cognitive changes that can occur with aging are more prevalent in the older group.

**Education Level** Unfortunately, the participants are not evenly divided between the two educational groups, so commenting on any possible correlation is difficult. The overall education level of this group of 16 elderly people is quite high. The mean educational level of the elderly population today is 12 years of education or less (Infanti). In this study, the group with less education had almost 20 percent more errors overall and a higher percentage of errors with each policy than the group with college and graduate degrees. These facts suggest that less education means more difficulty understanding and using these documents. We can only wonder how successful participants with less than a high school diploma would be finding information in these policies. The results from a

recent National Adult Literacy Survey of over 26,000 adults in the United States reveals that between 47 and 51 percent of the adult population cannot complete simple literacy tests. Certainly, many of those with limited literacy in the United States are from the elderly population, and they would not likely find the answers to any of the usability questions for these two documents.

Within the two education levels in my study, the participants are evenly divided between the two age groups. The 65- to 74-year-old group has five of the participants with college degrees or higher education, and the 75-and-older group has five with higher education. Of the participants with high-school diplomas, three are from each age group. These groups defined by education levels were not divided evenly between male and female. All of the participants in the lower education level were females. To better support the claim that education makes a difference, user tests in a future study could equalize the number in each group, equalize the age and gender factors, and add an education level of less than a high school diploma.

**Time on Task** Part of my methodology was to look at the time on task for each group and each policy to see if those numbers might suggest that one policy was more difficult to use or that one group took longer to find the information. The averages are given in Table 5, based on age groups, gender, and policies. After I completed the interviews and testing, I concluded that time on task is more a factor of specific individuals than of groups. Some participants talked a lot more, gave ancillary information, and took more time. Some of the participants wanted to read the information

**Table 5.** Average number of minutes per question for each policy is given by age and gender of the participants.

	<b>Policy A</b>	<b>Policy B</b>
<b>Average time on task (in minutes) for all participants</b>	3.0	2.5
<b>Males</b>	3.1	2.8
<b>Females</b>	2.9	2.2
<b>Ages 65-74</b>	3.2	2.5
<b>Ages 75 &amp; up</b>	2.8	2.4

very thoroughly once they found it, and others were satisfied with verifying that the information was there and then moving on to the next question. Also, some individuals gave up very quickly, while others were more persistent and gave up only reluctantly. For example, one participant (Pansy) was obviously worried about the time factor when she stated, "I hope you're not timing me," and later said, "I hope you're not in a hurry; it seems like it takes me a lot of time."

Two of the male participants (Charlie and Fanwell) talked a great deal more than the other participants and did not seem worried at all about the time factor. They both had wonderful stories to tell relating somewhat to each topic. Those two averaged 5.4 minutes and 3.8 minutes per question—well above the 2.7 minutes per question average of the total group of participants. Together, they probably account for the fact that on average the male participants consistently took longer per question than the female participants did.

One set of numbers from Table 5 that does appear to be of importance is the average time taken per question for each policy. Whether we look at the overall average time on task or the averages separated by groups, consistently more time was taken to find information in policy A than in policy B. While the figures given earlier indicated that participants' found the correct information with basically equal frequency in policy A and in policy B, the time on task data indicate that participants took longer to locate that information in policy A. According to Kostelnick and Roberts (1998, 190-91), several design decisions contribute to policy A being less legible:

- ◆ Right-justified lines often have irregular spacing, causing some distraction.<sup>16</sup>
- ◆ Text of 10-point or smaller font without increased leading is more difficult to follow across.
- ◆ Sans-serif type can also be more difficult to follow across without increased leading.
- ◆ Line lengths that are too long "can erode clarity."

In studies still frequently cited, Tinker (1963) tested one sans-serif type and nine serif types with users and found that, even though participants read as rapidly with sans-serif type, they did not prefer it. He also showed the importance of leading on smaller fonts, such as the 10-point font used in policy A:

Leading has an important effect on the legibility of type. While effective for improving the legibility of all sizes of type, leading has considerably less influence on 12-point type than on smaller sizes. (Tinker 1963, 106)

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<sup>16</sup> Kostelnick and Roberts suggest that people prefer variation in end points rather than the "visual monotony" of right-justified text.

In summary, the quantitative data from the user testing show that males did slightly better than females on the test, that more males performed better with and seemed to prefer policy A, and that the female participants performed better with and slightly preferred policy B. However, the males had an overall higher education level than the females, and the results show that the more education, the better the performance. The data also reveal that the old-old group had more incorrect responses than the young-old group. The young-old group did much better with policy B than policy A, while the old-old group showed little difference in incorrect responses with each policy. This difference in performance between the two age groups would suggest that the old-old group has experienced more physical and cognitive changes that impact their performance. The time on task information shows that on average participants, regardless of group, took more time to respond to questions in policy A than in policy B.

The quantitative data suggest some differences that appear to be important. Replicating this study by better controlling the characteristics of each group (e.g., making sure the education levels are the same for both males and females) would help confirm some of these differences. The qualitative data offer even more information about ways in which this elderly group used the two test documents.

### **Qualitative Data**

The qualitative data were drawn from the elderly users' responses and reactions to the documents during and after the tests and from my observations of the testers as they used the documents. As verified by the responses, in both documents, the information the participants were seeking was inaccessible to these participants 45 percent of the time.

Why did Dutch and Alley, well-educated retired engineers, both answer incorrectly for four out of six of the scenarios? And why did Louise and Mimi, who both handle all of the medical claims for their spouses and themselves, miss four out of six and five out of six, respectively, of the questions asked? While Louise, Mimi, and others are able to negotiate the complexities of these documents in dialogue with their health care providers, the documents were in fact intended to be understood and used by the customer without outside assistance.

I looked first at each of the questions to see if certain questions caused more problems than others did. Table 6 shows the errors by specific question and by policy. The descriptive data in Table 6 point to major problems for most participants with questions D and F. Questions C and E also appear to have been difficult for many participants. I looked carefully at the responses to these four questions in particular. I also looked at all the incorrect, incomplete, and/or missed responses. Based on my analysis of the responses and the errors for all the questions, I identified four categories of tasks that caused some problems for some of the participants:

- ◆ Pulling together two different pieces of information or recalling some prior knowledge to answer a question
- ◆ Using the tables of contents
- ◆ Misusing or not using glossaries
- ◆ Following document guides

#### **Pulling Together Information from Two Sources or Recalling Prior**

**Knowledge.** With question F, participants were asked whether the Medigap policies



**Table 6.** Error rates are identified by question and by policy.

	<b>Total % Errors</b>	<b>% Errors Policy A</b>	<b>% Errors Policy B</b>
<b>Question A</b>	19	25	13
<b>Question B</b>	25	38	13
<b>Question C</b>	44	50	38
<b>Question D</b>	56	63	50
<b>Question E</b>	44	25	63
<b>Question F</b>	81	75	88

helped cover doctor's office visits and, if so, how. As mentioned in chapter two, these Medigap policies are tied directly to Medicare coverage for the elderly. To answer this question, the participants needed to know that a doctor's office visit falls under Medicare part B (rather than part A). They either needed that prior knowledge or they needed to locate information somewhere in the document that indicates what is covered under part A or part B of Medicare, and then they had to look in another place in the document to see if these policies supplemented that coverage for doctor's visits. The question is very basic and relevant to all Medigap policyholders. Yet, as Table 6 shows, 81 percent of the participants were unable to correctly answer this question.

To answer question F in policy A, the participants had to have prior knowledge that doctor's office visits are covered under Medicare part B. This fact is not given anywhere in the policy A document. An excerpt from this policy document, *Section B: Benefits to Supplement Medicare Part B*, is presented in Figure 4 and shows how the information on coverage is provided.

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## SECTION B BENEFITS TO SUPPLEMENT MEDICARE PART B

Benefits are payable as follows:

1. When Medicare pays for Part B services and supplies, we will:
  - a. Pay the calendar year deductible, and
  - b. Pay 20% of your Medicare eligible expenses incurred for those Medicare Part B services and supplies, and
  - c. Pay 100% of the difference between the actual billed amount for those incurred Medicare Part B

services and supplies (not to exceed any charge limitation established by the Medicare program or a state law) and the Part B Medicare eligible expenses.

2. If you are charged a nonreplacement fee for a blood transfusion, we will pay this fee for the first three pints of blood in a calendar year.

If you are not enrolled in Part B of Medicare, we will pay benefits as if you were enrolled.

---

**Figure 4.** Policy A document gives some of the information needed to answer question F about coverage for visits to the doctor's office

To answer this question from policy B, the participants without prior knowledge must look on page one under *Important Information* at the section on *Medicare Part B* to find out that physician services are covered under Medicare part B. This section states that "Medicare Part B helps pay for physician services.... We offer you supplemental benefits of these two sections in all these categories as stated in the BENEFITS section...." Then the user must go to the *Benefits* section on page five (see Figure 5) to find out how those services are covered under this Medigap policy. The combination of these two sections then gives the policy user the answer to question F.

Only two out of the eight participants given this question about Medigap coverage of doctor's office visits in policy A answered it correctly, and both of those participants admitted prior knowledge of Medicare part B coverage. As evidenced by some sample quotations from the protocols, most of the other six gave up in frustration:

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**ONE HUNDRED PERCENT (100%) OF  
MEDICARE PART B EXCESS  
CHARGES**

---

We pay all of the difference between the actual Medicare Part B charge as billed—not to exceed any charge limitation established by the Medicare program or state law—and the Medicare-approved Part B charge.

---

**Figure 5.** Policy B lists information on physician coverage in the Benefits section.

Louise: [After scanning back and forth between several sections] “I’m in the wrong place, I think. I don’t think it pays. I’m just not in the right place. I’m not good at reading these things. Additional benefits to supplement.... I don’t...don’t see it. But I know that most policies do pay for some part of the doctor’s visit. I’m having trouble. That should be up here probably. Let’s give up on that.”

Pansy: “I’m not sure, is it Medicare B that is the doctor? I think it is. I’m not really sure, isn’t that terrible? ...I’m looking at *Exclusions and Limitations*, but you’d think that they would have a place somewhere that would tell you whether they pay for the doctor. Well, I suppose they don’t pay for it. ...No, I’m not finding it, but surely...I’m sure that it’s in here somewhere but I don’t find it. I can’t find it.”

Bottle: [Read through the correct section but was unable to understand the information.] “Will this policy pay for your doctor’s office? I don’t know. I don’t find it anywhere. I don’t see anything.”

Only one (Kay) out of the eight participants answering question F from policy B answered correctly. Her answer clearly showed a prior knowledge and understanding of what is covered under Medicare part B:

Kay [answering question F from policy B: “The Medicare part B would be your doctor’s visit. And, they pay all of the Medicare part B deductible amount for calendar year. They pay the difference between the actual Medicare

part B charge as billed. I don't know whether I can find anything else on that or not.

Pat: "How did you know that Medicare part B is doctor's office visits? Is that in here?"

Kay: "I just knew that, I guess. "

As these examples from the interviews show, the other seven either gave up or made assumptions without finding the information in policy B:

Charlie: "It isn't in there at all, that I have seen. Doctor's office visits...well, they should have that in here. Maybe I skipped over too fast. [Scanned back over the same pages.] Doesn't mention it under A. I suppose it would be under B. 'Pays for physician services.' It doesn't specifically say a doctor's office.... Well, it says physician services, but I don't see anything about doctor's visits."

Mimi: "They will pay for doctor's office visits. They will not pay for physicals. That's something I know. I didn't see it here. I know that. I really didn't see.... No, I do not see anything in here that says specifically about my doctor's office calls."

We can refer to research literature to explain why the process of finding this information might have been difficult for these elderly. Cognitive function, working memory, omissions, and psychomotor and cognitive speed are factors that affect reading processes. Changes in these factors that may occur with aging affect the elderly reader's processes. For example, one large cross-sectional study of elderly found a marked decline in each decade after 50 in reasoning and verbal memory after delay—the ability to recall information after both a time lapse and, typically, after some additional information has been given (Powell 1994). Policy A clearly expects the participants to have knowledge of Medicare coverage and to recall a part of it in order to be able to answer this simple question. One advantage of conducting think-aloud tests is that readers' responses often point out errors of omission or demands on recall ability, because often "...the biggest

problem with poorly written text lies not in what it says but in what it fails to say”

(Schriver 1989, 252).

A reduction in psychomotor and cognitive speed in the elderly may also lead to impaired cognitive functioning; thus, material processed at an earlier time might not be available later when it is needed (Jones and Bayen 1998, 677). As suggested by one of the retired engineering professors, this was sometimes a problem for the participants:

Bottle [in the post-test interview for policy B]: “I did have the question—and I’ve been over this a thousand times—between A and B, and I think B is normally the doctor’s. I guess I depend less on my memory than I use to.

Also, “older adults...are more likely to experience interference from irrelevant or surplus information” (Czaja 1990, 30). All of this evidence suggests that separating the relevant information (as was done in policy B between pages one and five) can be problematic, as was noted directly by three of the participants during the post-test interviews:

Flossie [the 74-year-old retired nurse]: “And in one place it says *policy provisions*, but you have to then go someplace else. It makes it more difficult to have to go back and forth from one place to another.”

Punjab [who was frustrated throughout the testing]: “Now look, *Medicare Part B Coinsurance, Medicare Part B Deductible*. Why aren’t these put together. Why aren’t they loaded up together instead of interspersing here. That doesn’t make sense to me at all.”

Sydney [continuing her criticism of policy A]: “It says *Section A Benefits*. Well, this is section B! It is *Payment of Claim*. All of the *Payment of Claim* information isn’t together. ...People are going to read this and they are not going to look on the next page to see what it says.... I’m sure that’s what it is, but it doesn’t say *Payment of Claims Continued*.”

Several implications can be drawn from these examples to aid writers/designers and companies in preparing information for the elderly. Technical communicators must

be aware of any assumptions they are making about this audience's prior knowledge of a subject. In the Medigap policies, Company A is assuming some prior knowledge of Medicare coverage. And in both policies, the documents' designs and texts focus on Medicare part A and part B and the ways the Medigap policies relate to those parts rather than on what the policies cover. Therefore, the elderly users are required to have some general knowledge of what falls under Medicare part A and part B in order to quickly find information. Why not make the Medicare part A and B information a sidebar and make the actual benefits the primary headings? Or, if keeping Medicare part A and B as major headings is necessary or desirable, writers should label second level headings in such a way as to clearly indicate the topic that follows. At a minimum, on a more local design level, policy B should physically place information together when knowledge of one piece of information is crucial to the understanding of other information. Both the global and local-level changes probably sometime mean repeating information. Because these documents are used episodically rather than read completely for retention, repeating information in some places is important. In addition, tables of contents can help the elderly access information.

**Using the Tables of Contents.** The group of elderly that I tested for my project appeared to rely frequently on tables of contents to assist them in finding information. Thirteen out of the 16 participants used the tables of contents at least once during their tests. I noted at least 36 instances when the testers looked to the tables of contents for help. In several cases, however, the participants did not find the listing that they expected to find to lead them to the correct section. In other cases, because of assumptions that the

participants made about this genre, they were not able to find the information in the policies even when they found the proper listing in the table of contents.

Figures 6 and 7 are copies of the tables of contents from both policies. Policy A, which calls its table of contents the *Index to Your Policy*, has the table embedded in the middle of the front page of the policy (see Figure 6 for a copy of the policy page that includes the table of contents for policy A). Policy B places the *Table of Contents* on the third page of the policy, and this table is the only information on that page (see Figure 7 for a copy of policy B's table of contents). Both tables of contents give only the beginning page number for sections even though the sections may cover several pages. While this practice is a publishing convention, at least five of the participants were confused by this, as represented by one participant's comments:

Pansy [reading from the table of contents in policy B during the protocol]:  
 "Well, on the front of it, it says something about the coverage for foreign countries...but I didn't see which page.... *Medically Necessary Emergency Care in a Foreign Country*—but it doesn't say what page. I guess I'll have to start through it and see [began slowly scanning the pages]."

Pansy, in her post-test interview about policy A, continued to admit confusion about the numbering in the table of contents:

Pansy: "I don't know; I think they should have it so you know where to look for stuff. Well, I guess they do in a way, but I can't find this. It says *Benefits Under Part B of Medicare*, and I don't know where it's at. Page 3, it says, and I don't see it!"

Review of the policy B table shows that the subheading *Medically Necessary Emergency Care in a Foreign Country* is listed under the heading of Benefits. But the only page number given is page three to the right of the main heading. The section on

**MEDICARE SUPPLEMENT  
PLAN F**

**NOTICE TO BUYER:**

**THIS POLICY MAY NOT COVER ALL OF  
YOUR MEDICAL EXPENSES**

**INDEX TO YOUR POLICY**

<b>IMPORTANT NOTICES</b> .....	Page 1	<b>EXCLUSIONS AND LIMITATIONS</b> .....	Page 4
<b>HOW TO FILE A CLAIM</b> .....	Page 2	<b>CLAIMS</b> .....	Page 4
<b>AGREEMENT</b> .....	Page 3	Notice of Claim	
<b>DEFINITIONS</b> .....	Page 3	Claim Form	
You, Your		Proof of Loss	
Benefit Period		Time of Payment of Claims	
Eligible Expenses		Payment of Claims	
Medicare		Physical Examinations	
Calendar Year Deductible Amount		<b>GENERAL PROVISIONS</b> .....	Page 5
Reserve Days		Consideration	
Accident		Entire Contract; Changes	
Sickness		Time Limit on Certain Defenses	
Hospital		Grace Period	
Skilled Nursing Facility		Reinstatement	
<b>BENEFITS</b> .....	Page 3	Suspension of Coverage	
Benefits Under Part A of Medicare		Legal Action	
Hospital		Misstatement of Age	
Skilled Nursing Facility		Conformity With State Statutes	
Benefits Under Part B of Medicare		Periods of Insurance	
		Membership, Voting, Annual Meeting	

Only the first page number of each section is given.

The headings labeled under **BENEFITS** are main level headings in the document (i.e., the same level as **DEFINITIONS**).

This is a legal contract between you and American Family Mutual Insurance Company.

**READ YOUR POLICY CAREFULLY  
IMPORTANT NOTICES**

**THIS POLICY** is a legal contract between you and us. We agree to pay your benefits for Medicare eligible expenses resulting from accidental injury or sickness based on the policy provisions up to the maximum benefit. These expenses must be incurred while this policy is in force.

**30 DAY RIGHT TO EXAMINE.** If you return this policy within 30 days after you receive it, we will return your money. Then, it is void as if it never existed.

**RENEWABILITY.** This policy is guaranteed renewable. If you change your place of residence, we may issue you a new policy (see page 5). This policy cannot be canceled for nonpayment of premium or for material misrepresentation.

**PREMIUM ADJUSTMENT.** Your premium may be changed if we change the premium for all policies of this form in the state where you live. Premiums also change because of changes in policy benefits resulting from changes in your health. Premiums increase yearly, on the first renewal date following your birthday.

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The subsection that includes care in a foreign country has been omitted.

This section is actually titled *Benefits to Supplement Medicare Part B*.

**Figure 6.** Policy A has an *Index to Your Policy* on page 1.



care in a foreign country (the place to look to answer question A) is actually on page five in the policy. This was the first question that Pansy was asked. After looking to the table of contents for help on this first question and not getting it, she did not return to the table of contents for any of the other questions. Dutch and Louise both also had the same problem with question A in policy B. Dutch was never able to find the correct answer, but Louise, with some signs of irritation in her voice, eventually discovered the answer during her test protocol:

Louise [during the protocol, looked at the table of contents and then went to page three]: "Well, it's supposed to be on page three. Hmmm. Medically Necessary Emergency Care in a Foreign Country. One, two, three. Well...well, unless I'm missing it, I don't see where it says a foreign country. Well, it's got to be somewhere else, because they have to have that. Humph, it's on page five.... Must be three to seven."

None of the current theories in other disciplines that I have researched adequately explains why this problem would occur with the elderly—why they would not notice the page number of the next major heading and realize that they potentially need to look over more than one page to find the information that they need. Does language have to be that explicit for many of the elderly? This particular problem of the need for explicit language and direction for an elderly audience could be an important topic for further testing.

The table of contents in policy A caused some participants problems with question A also because this table does not list emergency care in a foreign country. Under *Benefits*, a third subheading should be listed entitled *Additional Benefits to Supplement Medicare*, but this heading has been omitted. The information is found on page five and is the only information under this heading. Alley, april, Vic, Mimi, Punjab, and Fanwell (six of the eight who were given question A for policy A) looked to the table of contents

<b>TABLE OF CONTENTS</b>	
<b>IMPORTANT INFORMATION.....</b>	<b>1</b>
<b>BENEFITS .....</b>	<b>3</b>
Benefit Period	
Medicare Part A Coinsurance	
Medicare Blood Deductible	
Medicare Part B Coinsurance	
Medicare Part A Deductible	
Nursing Facility Days 21-100	
Medicare Part B Deductible	
100% of Medicare Part B Excess Charges	
Medically Necessary Emergency Care in a Foreign Country	
<b>SERVICES NOT COVERED.....</b>	<b>7</b>
<b>YOUR POLICY.....</b>	<b>8</b>
<b>GLOSSARY .....</b>	<b>13</b>

Only first page of each section is given.

No indication of what is included under Your Policy is listed.

Plan F

Figure 7. Policy B has a *Table of Contents* on the third page of the document.

first and then just started scanning the document. Six out of eight were able to eventually find the correct information but without the help of the table of contents. For four of the participants question A was their first question, so this question marked their first encounter with the table of contents in policy A. Regardless of success or failure with question A, all four went on to use the table of contents for subsequent questions. Often the participants blame themselves rather than the document design (or the table of contents) for their inability to find the correct answers:

April [looking at the table of contents during the protocol]: "*Payment of Claims* under *Claims*. *Payment of Claims*. I guess I really don't just pick up on being out of the country. If it's there, I'm not seeing it as I scan it. I'm probably reading too fast."

Punjab [also reading the table of contents during the protocol]: "I don't see here where it says while you're not in the U.S. of A. I suppose I would find it eventually.... This is an I.Q. test, you know that? My reading-five I.Q. is just firing away. [Laughs, somewhat embarrassed, and then finds the information while scanning the pages.]

Other design problems were noted in the tables of contents. The policy B table of contents lists only the main headings in the policy except for under the main heading *Benefits*, where it does give the subheadings. What is covered under the section *Your Policy* is not explained at all in the table of contents although a review of that section reveals 14 subsections, such as *Authorized Policy Changes* and *Effects of Termination*. Testing showed that omitting these cues in the form of subheadings required the participants to rely on recall of prior knowledge, if indeed they have that prior knowledge. During the post-test interview, Vic noted the omissions:

Vic: "The table of contents here [in policy B] is not as easy to follow. It is not as complete as the other one. The other one [policy A], it might be a little easier to find what you want in it. It's a little more complete in finding what you want. This one is easier to read but it is not as complete."

On the other hand, policy A, which lists all of the main and subheadings in its table of contents, has headings that are labeled differently there than they are in the policy, which caused users serious problems. Also, the level of the heading varies between the table of contents and where the sections appear in the document. When asked during the interview specifically about the table of contents in policy A, Bottle said, "I didn't find that helpful at all. I didn't find that helpful." Flossie was another participant who also reported that the table of contents in policy A was not helpful.<sup>17</sup>

Flossie [during the interview]: "Well, I didn't find what I was looking for there, but then what they do have does seem to be on the page they say. But then again, it is hard to read the index [table of contents]."

No clear pattern could be discerned from how the participants used the tables of contents. For example, Alley did not look at a table of contents until the fourth question. He did not find what he was looking for and continued to scan the document. He did not return to the table of contents for any other questions. Mimi also did not look at a table of contents until the fourth question, did not find the help that she needed, and then did not return to it. Flossie did not look for information in the tables of contents until the last question. While all of the participants, except for Sydney, used one or both of the tables of contents at some time during the testing, we can not say why they chose to use the tables when they did or why they did or did not go back to the tables—some found what they needed and did not refer back to the tables, and some did not find what they needed but continued to use the tables of content.

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<sup>17</sup> Interestingly, I noted that several participants, when unable to find a listing in the table of contents for a specific benefit, would go to the section on *Exclusions and Limitations* in policy A and the section on *Services Not Covered* in policy B. Their reasoning, in several instances, was that if a benefit or service is not excluded in these two sections, then it must be covered.

In a table of contents, the main divisions should be listed and the page number where that division begins should be listed (Rude 1998, 69). In addition, “An effective *table of contents* uses subject headings, not section labels, to identify major sections and subsections of a report” (Burnett 2001, 623). Technical writers/designers and the companies that they work for would do well to pay specific attention to tables of contents when preparing documents for the elderly audience. The results from my tests suggest that most elderly users frequently rely on tables of contents to guide them to specific information and that these elderly make certain assumptions about this genre. They assume that the specific page number for that information will be given in the table of contents. At the very least, they expect to have all inclusive page numbers (e.g., pages 3-7). These users also assume, as Burnett suggests, that the table of contents headings will reveal the subjects included in any section:

Alley [in the post-test interview after policy A]: “...I thought ‘foreign’ was going to come out. And then *Additional Benefits*.... And I thought, *Additional Benefits*, I’m not looking for that. I’m looking for ‘foreign’.”

In policy A, if a reader does not have prior knowledge of Medicare part B, he/she will not know what subjects fall under the subheading *Benefits under Part B of Medicare*. In policy B, readers likely will have no idea as to what subjects will be included under the heading *Important Information*. Clearly, tables of contents are one key to elderly audiences finding information within a technical document. Technical writers need to be aware of this fact and, when preparing documents to be used by an elderly audience, carefully design, label, and test the table of contents.

**Misusing or Not Using Glossaries.** As with any document, understanding the terminology in the Medigap policies is key to the audience's understanding of the contents of the documents. Both of the Medigap policies contain glossaries. Medicare requires that Medigap policies include a specified list of definitions. The companies have some discretion as to where they place the glossary, and they can certainly add to the list. Policy A includes a list of *Definitions* (not labeled glossary) in the middle of page three. And then whenever those defined words appear in the text of the policy, they are bolded. Policy B contains a *Glossary* at the end of the document on pages 13 and 14. Policy B defines the same Medicare-mandated terms, but also defines some additional terms. This policy does not bold the terms when they appear within the text. Since the words found in the glossary are not highlighted in any way within the text, the participants have no preview of what they will find in the glossary. I am not convinced that bolding or in some way highlighting the terms that are defined in the glossary is actually helpful to these users. Only one of the sixteen elderly participants looked for a definition in the glossary (in this case policy A's glossary).

Also, when scanning through the definitions in the policy A document, five participants looked to the information in the definitions for their answers to some of the questions. Sydney, Pansy, Dee Dee, Louise, and Dutch all began reading the definitions as they were looking for answers to questions. Louise and Dutch both finally realized that as definitions these would not give them the complete answers and looked beyond into the document for their answers. The other three, however, actually used that incomplete information from the section of definitions as answers to questions. When asked whether the policy covered the Medicare part A and part B deductibles, Sydney took her answer

from the definition for *Calendar Year Deductible*, which just explains what the deductible is. The definition does not talk about that policy's coverage of the deductible. A future research question, and one not addressed by this project, would be to ask whether some elderly users assume that information about one topic will be all in one place.

Some participants had other problems with finding definitions. Sydney, Charlie, and Vic were all unable to find the meaning of a particular term, as evidenced by their comments during the protocols:

Sydney [continuing her complaints about policy A]: "Let's see, the actual billed charges up to the coinsurance amount. I don't know what the coinsurance amount is and I don't see a definition for it. I really don't. This makes no sense...I was looking for some more information on what the coinsurance was."

Charlie [wasn't sure about the terms "physician services" and "doctor's office visits"]: "Pays for physician services, outpatient hospital services, durable medical equipment. I suppose it is physician services. It doesn't specifically say a doctor's office.... Well, it says physician services. But I don't see anything about doctor's visits."

Vic admitted some confusion in policy B about whether nursing facility meant skilled nursing care. In this case, the glossary in the back of policy B did define nursing facility and specifically mentioned skilled nursing services. However, Vic did not look at the glossary in the back of policy. None of the participants ever looked at the glossary in the back of policy B. The term coinsurance was defined in policy B, but not in policy A where Sydney had the question. The term physician services is not defined in either policy.

The placement of the glossary and the terms included within it are important to the elderly audience (most likely to all audiences). Placing it in the beginning can be useful "...when readers are unfamiliar with the information and must know the terminology in

order to comprehend the document” (Burnett 2001, 343). But placing the glossary in the beginning can also be a problem because “...readers may lack a frame of reference and may not be able to judge which terms to focus on” (Burnett 2001, 343). Placing the glossary at the beginning of the policy was a problem because some participants used it as complete policy coverage information. Placing the glossary at the end of the policies is also a problem because no one looked to the end glossary for information. The elderly appear to comprehend more when information is close together—when they are not required to hold one piece of information in working memory while searching out another or when there is little distraction in between connected information. This audience might be better served by having definitions given when the term is used within the document and when understanding the terminology is crucial to understanding the information given. Advocates of plain language recommend “...placing a box defining the words on the same page where the word is first used” (Plain Train Web site). Determining which terms to be defined could be aided by some simple surveys of elderly users. In the absence of testing, because of potential decreases in working memory of the elderly, providing more rather than fewer definitions might be beneficial to this audience. Again, given the episodic nature of use of these documents, placing definitions throughout the document could result in a need to repeat definitions in some instances.

**Following Document Guides.** A review of the ways in which these two policy documents were organized to present their information shows some design elements (or guides) that were troublesome for these elderly users and some that seemed to be helpful. We can look at the three levels of design—textual, spatial, and graphic—within these



documents that should help readers move through the information. The textual level designs include such features as type and size of font, use of bolding or italics, use of upper- and lower-case letters, size and levels of headings, and numerical listings. An important concept in understanding document design is "...the most basic and useful Gestalt principle [of] figure-ground contrast.... When we look at a whole page...(the Gestalt), we look for global variations across the entire visual field" (Kostelnick and Roberts 1998, 53-4). These variations allow us to find something on which to focus. A full page of continuous unbroken text provides the reader with no focal points, no place to begin to find information. Helpful figure-ground contrast is achieved by headings of various size and placement; paragraph breaks; listings; print style, size, and variation; bolded print; and other techniques.<sup>18</sup> These elderly users relied heavily on a few of these figure-ground contrast elements to guide them through these documents. Without exception, each participant either admitted to reading the headings or they read them aloud as they were taking part in the tests. Several participants also admitted to looking to bolded words for guidance. And others commented on print size.

These two policies present contrasting textual designs. Figure 8, which presents a sample page from policy A, shows bolded centered main headings, which definitely create a focal point for the reader. The headings should indicate the hierarchy of information presented and should be consistent with the levels in the tables of content. In policy A, the headings of the sections are confusing. *Section B* and *Section C* are actually subheadings under the major heading of *Benefits*; yet, they are presented as the same level

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<sup>18</sup> See Kostelnick and Roberts (1998) for a review of the levels of document design and Burnett's (2001, 247-62) discussion on information design for an in-depth look at the three basic levels of document design.

as the major headings of *Exclusions and Limitations* and *Payment of Claims*. The major headings are centered, in all-cap letters (for emphasis), larger type, and bolded; so they do stand out. The second level of headings is usually (but not consistently) found at the beginning of paragraphs. They are all upper-case bolded letters in the ten-point font of the rest of the document. Although none of the participants complained about the headings in the interviews, the inconsistency in the headings could potentially account for the increased time the participants needed to find information in policy A.

Policy A also uses bolding of information within the paragraphs as a design feature, which is usually an indication of importance. Several different words are bolded throughout, such as **you**, **your**, **we**, and **Medicare**. These words are actually the words given in the glossary in the front of the policy. They are bolded each time they appear anywhere in the document. As evidenced by the examples from the interviews, some of the participants found this design feature to be problematic and distracting:

Dutch [in a post-test interview]: "There is too much here [in policy A] that is written in bold—you, we, and all this stuff. You wonder why this was all put down there like that."

Sydney [continuing her diatribe against policy A]: "These *we*, *you*, *your* are all dark print. Well, we know who *you* is. And I noticed they dark printed all the Medicare, everything that says Medicare. See, this is...you know, if you're scanning you look for dark print thinking that would be more important and are *we*, *you*, *they*? I don't see a reason to do that and I don't see a reason why Medicare has to be bold-faced. It does [hinder] because your eyes are drawn to those, and you don't read the words that are important. You know, the stress is in the wrong place. I think."

Another design decision in the policy A document, as evidenced by Figure 8, was to use a ten-point sans-serif font with little leading. "Because sans-serif typefaces are

## SECTION B BENEFITS TO SUPPLEMENT MEDICARE PART B

Ten-point sans serif font is used.

Benefits are payable as follows:

1. When Medicare pays for Part B services and supplies, we will:
  - a. Pay the calendar year deductible, and
  - b. Pay 20% of your Medicare eligible expenses covered for those Medicare Part B services and supplies, and
  - c. Pay 100% of the difference between the actual billed amount for those incurred Medicare Part B

services and supplies (not to exceed any limitation established by the Medicare state law) and the Part B coinsurance expenses.

Numbers and letters are used for listings.

2. If you are charged a nonreplacement fee for a blood transfusion, we will pay this fee for the first three pints of blood in a calendar year.

If you are not enrolled in Part B of Medicare, we will pay benefits as if you were enrolled.

Section C should be a lower level heading than EXCLUSIONS AND LIMITATIONS

## SECTION C ADDITIONAL BENEFITS TO SUPPLEMENT MEDICARE

1. Emergency Care in a Foreign Country  
We will pay for care received in a foreign country as follows:
  - a. First you pay a calendar year deductible of \$250, then
  - b. We will pay 80% of billed charges for Medicare eligible expenses for medically necessary emergency care (hospital, physician and medical) received in a foreign country which care would have been covered by Medicare if provided in the United States, and

- c. Which care began during the first 60 days of each trip outside the United States, subject to

- d. A lifetime maximum of \$50,000.

For this benefit, the additional definition applies:

**EMERGENCY CARE** means care needed immediately because of an injury or an illness of sudden and unexpected onset.

All headings, subheadings, and terms listed in definitions are bolded.

## EXCLUSIONS AND LIMITATIONS

Inconsistent spacing occurs between listings.

**SERVICES NOT COVERED BY THIS POLICY.** No benefits provided for:

1. The daily co-payment amount under Medicare Part A for skilled nursing care above the number of days covered by Medicare.
2. Medicare eligible expenses incurred while your policy is not in force.
3. Any expense or portion of expense not covered by Medicare except as noted in the benefits section of this policy.
4. Outpatient treatment for mental illness beyond what Medicare pays.
5. Private duty nursing.
6. Custodial or intermediate nursing care.
7. Self-administered drugs or biologicals.
8. Charges for the care, treatment, filling, removal, or placement of teeth or structures directly supporting the teeth.
9. Expenses for physical examinations and directly related tests, eye exams, or eye examinations for the purpose of prescribing, fitting, or changing eye glasses, or hearing aids.

10. Charges for cosmetic surgery, except for the prompt repair of accidental injury and for the improvement of the functioning of a malformed part of the body.

11. Charges for routine foot care, orthopedic shoes or supportive devices of the feet.

12. Charges which neither you nor another party on your behalf has a legal obligation to pay.

13. Charges paid directly or indirectly by any governmental agency.

14. War or any act of war.

15. Personal comfort items.

16. People not covered by Medicare Part A and Part B.

17. Payment that has been made, or can reasonably be expected to be made, under a worker's compensation law or plan of the United States or a state.

18. Charges imposed by your immediate relatives or members of your household.

19. Home health care above the number of visits covered by Medicare.

We will not duplicate any benefits paid by Medicare.

The right margin is justified.

New sections continue onto next page.

## PAYMENT OF CLAIMS

On all claims matters, contact American Family Mutual Insurance Company, 8000 American Pkwy. Madison, Wisconsin 53783-0001.

**NOTICE OF CLAIM.** You must give us written notice of a claim. The notice must identify you and your policy number.

**CLAIM FORM.** When we receive the notice of claim, we will send you forms for filing proof of loss. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

The text is dense with minimal leading.

Figure 8. Sample page from policy A illustrates document design features.

simpler, the letters don't have as many distinguishing features, making them slightly more difficult for some people to read" (Burnett 2001, 259). The minimal leading used in policy A document creates the illusion of *visual noise*. "Noise is anything that impedes our perceptual response to sensory stimuli" (Kostelnick and Roberts 1998, 58)—in this case to textual information. That visual noise can occur with sans-serif text that has little leading, "Because the lines of text don't have any breathing room, the text looks jumbled and dense. We have to work hard to distinguish the text from...other lines of text" (59). Some of the participants agreed, as these examples from the interviews indicate, that the text becomes difficult to read:

Punjab [comparing the two documents in his post-test interview]: "I think this [policy B] is easier to read for most people than this [policy A]. Having been an optometrist, I would know about this. Very often a person will lose his place [in policy A]. Let's see now which line was I on and trying to find it over here—following everything with his finger."

April [also comparing the two documents in an interview]: "This one [policy B] seemed to me—it was much simpler for me.... The other [policy A] you really have to look through a lot of stuff to find out what you're looking for."

Perhaps Charlie said it best, "Now, [Company A] could afford a few more pieces of paper to make that larger."

A few of the components of spatial design to consider in the policy A document include vertical spacing, line lengths, and margins. A look at the page from policy A presented in Figure 8 shows dense text vertically, a two-column design, and a right-justified margin. Sydney is one of the few to mention any of these design features when she complained about the "...four pages, closely typed" of policy A. Punjab, as mentioned earlier, suggested that in this policy readers can easily lose their place. Right-

justified text results in lines that are all the same length, and readers can easily lose their place in such texts.

The policy A document does not contain a lot of graphic features (beyond the very basic ones such as punctuation marks and the running footers), but this document might have benefited from the use of bulleted lists (a common graphic element in documents). As exemplified in Figure 8 under *Exclusions and Limitations*, this document frequently uses numbered lists. Numbered lists suggest some chronological order or some prioritizing of items. The list under *Exclusions and Limitations* appears to be of equal weight and importance—information best conveyed by the use of bullets. Also, the inconsistent use of white space between the numbered items within the listings could be confusing to readers. This design element was not mentioned by any of the participants, but a somewhat differently designed test might show that numbered listings with inconsistent spacing in this instance slow down users when they look for information.

Figure 9 is a copy of a page from policy B. The policy B document designs and guides are very different from policy A. The textual elements, such as headings, are designed differently. The major headings are separated and at the top of every page assigned to that heading, and they are bolded all-cap letters. The subheadings are also bolded, outlined by dark lines, and separated by more white space than we see in policy A.

The policy B document textual features, like policy A, also include the use of bolding. Policy B bolds all headings and advance organizers as well as the first few words of each point in bulleted lists. Policy B does not bold or identify in any way the words that appear in the glossary when those words appear in the text. Usually those defined

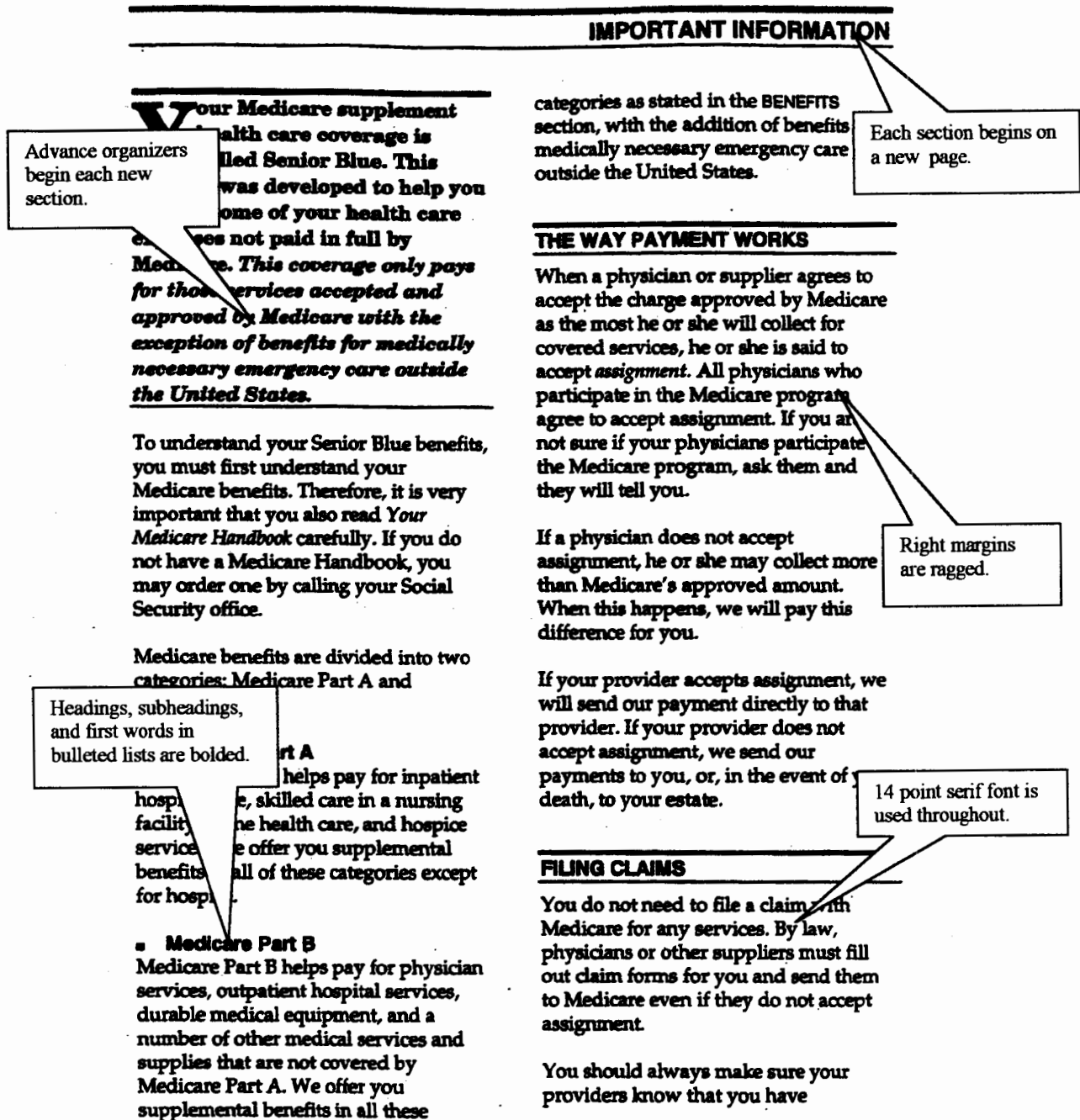


Figure 9. Sample page from policy B shows document design features.

words are bolded, italicized, or in some way made to stand out as an indication that they appear in the glossary. The fact that glossary terms in policy B are not cued in any way perhaps explains why none of the sixteen participants in this test used the glossary.

Again, the testing methodology could have, and perhaps should have, included some questions to determine if the failure of the document to identify the defined words (by bolding, italicizing, etc.) explains the lack of use of the glossary in this document.

In contrast to policy A, policy B used a 14-point serif font. Of the design features mentioned in policy B, as these examples from the post-test interviews suggest, the size of the type and the headings were most frequently praised:

Dutch [after completing the tests on both policies]: "This one [policy B] is much easier because it is laid out better I think. The headings, larger print—it's just easier to read. It doesn't look like it is that complicated."

Flossie [in her first post-test interview]: "Well, the headings [in policy B] stood out quite nicely. That helped me. It made things easier to find."

Sydney: "It's a good size. The print is big enough even for people with problems to read... I think people will refer to this [policy B] because the print is bigger. It's well laid out."

Charlie: "The print is a good sized print. And you can't help but be able to read the quality of the print. And they have it well organized here too.... Well, this is a lot simpler to read as I say because of the larger print and it is not jammed in fine print on the same page."

A look at the spatial design of policy B shows much more vertical spacing, a two-column design, and ragged right margins. All major sections begin on a new page. Also, each major section begins with a brief one-paragraph advance organizer to give the user some idea of what is in that section. The above comments would suggest that some of these design elements were helpful for the participants as they went through this document. A project researching the effectiveness of advance organizers with elderly

learners showed that "...the elderly appeared to have benefited from advance organization.... The basic results...suggest that advance organization helps older adults most effectively with recognition tasks...[especially for] adults of limited verbal abilities" (Thompson 1998, 635). One person in his post-test interview did comment on the advance organizers used in the design of policy B to begin each new section:

Dutch: "Here's the major title you expect to find in this one chapter [in policy B] and then this goes into more detail about what this says up here [in the advance organizer]."

Pat: "So the first part lets you know what you are going to find on that page?"

Dutch: "Yes."

Pat: "Do you think that is helpful?"

Dutch: "Yes."

Policy B does use one specific graphic design feature that was not tested but should be mentioned. Supplementary information on Medicare benefit periods was given in shaded boxes. The information in these boxes was not relevant to the questions asked of the participants, and the participants seemed to be able to ignore this intervening information. Neither my notes nor the transcripts reveal anyone reading that information. An interesting question to research is ways in which the elderly user perceives information in a shaded box. Is it perceived as irrelevant based upon the design? Or, because of visual changes that often occur, do the elderly find the shaded information more difficult to read because of the decrease in contrast?

Technical writers and designers need to be aware that certain design features at the textual, spatial, and graphic levels may work better for the elderly audience than others. The work done in this research project supports the idea that, with additional research, we can determine with some certainty what textual and design features are most appropriate for the elderly.



## Synthesis

Charlie, April, Pansy, Vic, and most of the others were determined to help me with my research by completing the user tests. In doing so, they provided me with a lot of information about how elderly individuals read and respond to documents such as these Medigap policies. This information allows us now to look back at the issues raised at the beginning of this chapter, to see what the results showed and to apply this information to my research questions.

On the issue of how the participants did answering the questions, the quantitative data shows that these active, elderly participants were able to answer the six questions correctly only 55 percent of the time. The questions asked are relevant to any Medigap policyholder, and the answers reveal basic information that a policyholder would need to know. Yet, almost half the time, these elderly users with above-average education were unable to find the information they were seeking in these two documents. Sydney, a retired registered nurse and social worker, with extensive experience in a medical field, missed one-third of the questions. Vic, a former engineering professor at a major university, missed half of the questions. And, Alley, who for many years worked as a design engineer for the federal government, missed two-thirds of the questions.

A review of the participants' performances when separated by different characteristics shows that males were somewhat more successful than female participants. The male participants, however, also on average have a higher education level so gender and education are confounded. The young-old group that was 65 to 74 years old made fewer errors than the old-old group that was 75 and older. These two age groups are equally divided by education levels and by gender. Although the dividing line between

the two age groups is arbitrary, the difference is perhaps correlated to a greater change in senses, cognitive function, and psychomotor and cognitive speed with increased aging. As the 2000 census shows a notable increase in the population above the age of 85, even more research into the ways in which the old-old adult population uses documents is warranted.<sup>19</sup> Dividing the group by education level shows a greater success rate in the testing for those with a higher education level. Because the group of participants is not evenly divided between the two education levels, I can only say the numbers suggest a correlation. User tests designed to focus on education level and designed to include even participants with less than a high school education and with limited literacy would provide more insight into how much education levels affect document use as people pass the age of 65.

As I look at how participants seem to be hindered or helped by any design or textual elements in the two documents, I can use the information gathered in this project and begin to answer my second research question on how technical communicators can write and design documents for the elderly. Trying to recall prior knowledge of Medicare information learned, or at least exposed to, over the past few years was a problem for many of the participants. Gathering information from one point in a document, holding the data in memory, and connecting that data with additional information located elsewhere in the document was also a problem for several of the participants.

All but one of the elderly that I interviewed and tested used the tables of contents in the two documents—sometimes with success, more often without success. A table of

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<sup>19</sup> The 2000 census shows the 85-years-and-older population in the state of Iowa increased by almost 18 percent since 1990, according to a May 18, 2001 report in *The Des Moines Register* (1B).

contents is a design element that apparently the elderly user finds desirable in a document. The group that I tested, and perhaps most elderly, make some assumptions and have some expectations about the genre of tables of contents. They expect the tables of contents to be detailed and specific—directing them very clearly to the right page and location. They assume that they will be able to recognize the labeling of pertinent information in the tables. And they sometimes have trouble if the tables of contents omit information and require recall of prior knowledge.

Glossaries are another design element of the documents that the participants did not or could not use. Some of the participants noticed, read, and/or interpreted the definitions given in the front of one document, but no one really used that list to find the definition of a term. Also, not one elderly participant looked to the glossary at the end of the other document for information. Although the interviews showed evidence of some confusion over terminology and a need for some definitions, evidently listing definitions together in a glossary is not a useful design technique for this group.

From my observations and the participants' comments, I noted several different textual and spatial design features that these elderly participants relied on as they looked for information in these two documents. They commented on the style and appropriateness of the headings, the use of bold typeface, the font size, the amount of leading (or density of text), and the chunking of information. These comments can guide us in the very early stages of preparing guidelines for writing for the elderly. Other textual features that are used in the documents and that might be important to the elderly, require additional focused testing or questioning—such as justified versus ragged right margins, the use of shading or other techniques to indicate important or supplemental

information, bulleted lists versus an outline format, and serif versus sans-serif font, among other possible design features.

After reviewing the qualitative and quantitative information produced from this project, let us look now again at the basic research questions of this thesis. The first question is "How do elderly individuals read and respond to documents they are typically expected to use?" This research project gives very definite evidence of about ways in which the elderly (in this case an educated, middle-class group of elderly) read and respond to two pertinent Medigap documents.

That information about the existence of different reading and response methods on the part of the elderly leads to the second research question: How can technical communicators write and design documents for the elderly and why they should be concerned about this audience? The growth in the elderly population (especially the old-old group) alone justifies writers' concern for this audience. Also, the fact that the elderly are healthier, more active, and more productive than ever before, which suggests that they are and will continue to be users of our documents, also lends support to writers' concern for this audience. Technical communicators should note that "...like all audiences, [the elderly] respond to the same principles of good communications that their younger counterparts do" (Sansbury, 1). Any documents designed for the elderly must first adhere to well-established principles of good communication. But we know, however, as some of the research cited in this thesis confirms, that at some point during the elderly years, adults do experience age-related mental, physical, cognitive, and social changes—with individual variations in when changes occur, how they occur, and in which areas they occur. We also know that those changes can affect the ways in which elderly people

process written information. An awareness of those changes and the impact of those changes on processing information can guide writers in determining which of their current writing and design techniques will most likely work for the elderly and which must be altered.

### **Techniques in Writing for the Elderly**

Without losing sight of the complexity of this group and the unique individuality of its members, just as any time writers try to understand their audiences, we must look to some commonalties for guides. With the elderly audience, those commonalties are in the physical, cognitive, and social changes that occur at some point during the elderly years. As we learn more and more about those changes and the impact of those changes on an elderly person's techniques for processing information, such as I have discovered in this research project, we can add to a growing list of guidelines for addressing this audience. This initial list of guidelines for addressing an elderly audience in a print document is a combination of contributions from gerontology, cognitive psychology, human factors studies, and from this research project:

Several of the guidelines for addressing an elderly audience are based on physical changes. Some of these guidelines are based on frequently noted changes in vision that occur with aging:

- ◆ Type size of twelve points or larger is preferred.
- ◆ Crisp serif font styles are easier to read.

- ◆ Increased leading, more vertical white space, and ragged right margins make lines of print more legible and easier to follow across.
- ◆ Strong figure/ground contrast with type, and especially with colors, aids elderly readers with visual changes.
- ◆ Clear and concise labeling of headings allows the elderly reader to find information easily. (Headings appear to be the most frequently relied upon design element, as evidenced by the elderly participants in this project.)

Other guidelines are based on the general physical slowing that occurs with aging and on the impact of fatigue on the elderly user:

- ◆ Avoiding the visual noise of too much bolding, too little white space, and unnecessary information reduces the need for the elderly user to filter the information.
- ◆ Chunking information in small units helps to decrease any impact of fatigue on comprehension.
- ◆ Designing highly contrasted, explicit, and relevant document guides (such as heading designs, tables of contents, and the use of bolding and italics) allows for easier processing of information and speeds up the elderly user's ability to move through the information.
- ◆ Making the table of contents detailed and specific by listing more than just the primary headings helps the elderly user navigate through a document.
- ◆ Placing definitions where the words first appear, and sometimes in subsequent appearances, will decrease the need for recall of information and will decrease

the amount of filtering of information that might be necessary if the glossary is in the front of the document.

Other guidelines are based upon possible cognitive changes in the elderly (e.g., decrease in short-term memory, decrease in working memory capacity, and slowing of cognitive processing):

- ◆ Requiring recognition rather than recall accommodates for any decrease in short-term memory loss.
- ◆ Grouping relevant information and related topics together reduces the amount of working memory required of the user and reduces intervening irrelevant information that has to be filtered out.
- ◆ Labeling that shows related information is continued to a second (or third, etc.) page when it cannot be presented all on one page provides more explicit information for the elderly user.
- ◆ Repeating information when related to different topics within a document also aids working memory and decreases the elderly users' reliance on short-term memory.
- ◆ Using illustrations with text when possible increases understanding and reduces the demand on working memory.
- ◆ Following all table of content listings with corresponding page numbers rather than just giving inclusive numbers after the main headings makes the table of contents more useful for all elderly users.

- ◆ Using advance organizers when possible can help the elderly user with recognition and processing of information.

By following these guidelines, writers will increase the elderly users' ability to find information within a document and will, perhaps, decrease the likelihood that the elderly user will give up before finding pertinent information.

Recognizing that we can identify ways to write and design documents more appropriately for an elderly audience then leads us into a discussion of my third research question: "What ethical responsibilities do both writers and their companies have to make information more accessible to the elderly audience?" In the next chapter, I further discuss three identified theories of business ethics and show ways in which these theories support the argument that writers and their companies are ethically responsible to consider to the elderly.



## CHAPTER 4: THE ETHICS OF WRITING FOR THE ELDERLY

*On a recent flight across the country, I was seated by an elderly woman. During my extended conversation with her, I became excited as I realized that this chance meeting was more proof of the existence of an incredibly active and vibrant elderly population. This 78-year-old lady—I'll call her Dottie—was not one of my test subjects, but her story adds a great deal of support to the argument that we should research and learn how to write for this audience.*

*Dottie is a very friendly, talkative 78-year-old woman. A rather large woman, she moves slowly in deference to the artificial knee she now depends upon. She told me, with a certain amount of pride, about a cookbook for people on dialysis that she and a dietitian had cooperated on and published. The idea for the recipe book came after the years she spent caring for her late husband and carefully controlling his very restricted diet that was required because he was on dialysis. Dottie and her co-author are currently working on a recipe book for diabetics. She spoke with authority about the new software program she had selected for converting recipe amounts, saving her hours of figuring by hand. Before the airplane landed, Dottie handed me her business card and suggested that I, as a registered nurse, might be interested in her Web site. She said that they sell their cookbook over the Web and also offer a lot of additional information for dialysis patients and their families.*

*Dottie started her professional career at the age of 75. She earned a bachelor's degree in nursing as a young woman but left nursing to stay home and raise her seven children and then to care for her invalid husband. Now she is a businesswoman, reading software instructions and publishing cookbooks. Dottie is proof of how vibrant, productive, and, in her case, entrepreneurial the elderly can be.*

The 16 people that I interviewed, and the many other elderly such as Dottie that I have met, are all unique individuals, most of them active, productive, interesting, and involved citizens. They are all reading and relying on many documents created by technical communicators. Given that we are beginning to understand how to write and design documents for the elderly, the next questions is, "what ethical responsibilities do writers and the companies they work for have to make information more accessible to the elderly audience?" In this chapter I use three different theories of business ethics to argue

that now that we are beginning to know how to write and design documents for the elderly readers and users, writers and companies have an ethical obligation to do so.

### **Ethical Responsibilities of Companies**

In the first chapter I discussed three different ideas of what business ethics includes. We can look along the continuum of these selected business ethics theories to see how writing appropriately for the elderly audience fits positively into each theory. In the sample documents used for this project, the elderly participants are customers. Depending upon the documents being discussed these same elderly may occupy different stakeholder positions.

**The Stockholder Theory.** According to those who support stockholder theory, a company's ethical responsibility is to its stockholders and primarily lies in increasing profits for those stockholders. Decisions should be made with that responsibility in mind. We can argue, in the case of Medigap policies, that learning to write and design policies that the elderly can easily understand and use could potentially increase profits for the stockholders. The life-cycle cost of a product (e.g., a Medigap insurance policy) would include the cost to develop the product, the cost to market the product, and the cost to service the product. Clearly, researching, user-testing, and redesigning during the development phase adds some cost to the product. A well-tested document, however, will likely need less revision, somewhat offsetting the cost of testing. A well-designed and tested product can be marketed to both the elderly audience and to insurance agents as a product that has been design-tested by people 65 years old and older. Insurance agents, as

well as the elderly buyer, will have more confidence in the product thereby leading to increased sales and increased profits. A well-designed policy should also result in fewer complaints and fewer questions from elderly consumers, resulting in a lower cost to service the customer and thereby increased profits. Poorly designed texts cause more misunderstandings, errors, complaints, questions, and staff time lost to problem solving. As advocates of plain language would argue (Plain Language Web site), when language matches the needs of the reader with those of the writer, the results are effective and efficient communication.

For many companies, the information that is gained in user testing a particular document, in this case with an elderly audience, can often be carried over to other products. I have seen other policy documents from the same companies in this study designed much the same way as their Medigap documents. Certainly, what we learned from testing the Medigap documents can be applied to many of their other documents. As a result, the other documents are improved, and the cost of the testing becomes less when that cost is spread out over several documents.

Beyond the example of Medigap policies, we still need to understand how to write for an older audience for most of the other documents that are designed and written for a company. As indicated in statistics reported earlier in this thesis, the population over the age of 50 controls a large percentage of the financial wealth in this country. Many of the people over the age of 65 are the company stockholders. So, a company's responsibility is to not only make more profit for these stockholders but also to provide information to them in well-designed documents.

**The Stakeholders Theory.** The stakeholders' theory of business ethics supports the idea that a company is ethically responsible to all of its stakeholders. Those stakeholders include all of a company's constituents: stockholders, customers, employees, and suppliers. Decisions should be made within a company by balancing, as much as possible, the needs of all the stakeholders. We have already seen above how, in the case of the insurance companies, designing an appropriate document for the elderly customer can be in the best interest of the stockholder. Obviously, the best interest of the elderly as customer, another stakeholder, is served this way as well. The policyholder will be able to make more informed decisions and to remain more independent from third party interpreters. Currently, many very bright, capable elderly individuals, as exemplified in this post-test interview, admit they do not know what their policies include:

Dutch (a retired engineer): "I have so much paperwork. I have volumes of papers.... But as far as me knowing exactly what's covered in my supplemental policy, I know enough, but I don't know as much as I possibly should. And I would be scared to death if someone else came along and said, 'Here, this is better than [your policy]. Will you change?' I would say no because I would be scared that I would be giving away something in my policy [without realizing it]."

And, again, developing an understandable policy is in the best interest of the employee. The insurance agent will have confidence in the product and feel comfortable selling the product. The office will receive fewer complaints and questions because the customers will be able to understand what they are getting in a Medigap policy and will be able to find information within that policy.

If we look at documents beyond the policies studied in this project, a company could find an elderly audience in many of its constituencies. As suggested above, the elderly may be a part of the stockholders group. Also, a company certainly may find, if

not now then in the future, a large number of elderly in their workforce. Since the enactment of the law in 1994 banning age-based mandatory retirement, the improvements in health care and disease prevention increasing longevity, and the push to increase the age at which social security benefits begin, a significant number of the elderly remain in the work force. As employees, this group will be reading internal as well as external communication.

**The Social Responsibility Theory.** Finally, at the far end of the continuum from the stockholders theory is the theory that companies should act ethically because it is the socially responsible thing to do. Also, companies should act ethically because "...it reflects upon how the company sees itself" (Martin 1998, 49). Martin suggests that if a company makes questionable ethical decisions (e.g., decisions that exploit employees or cheats or shortchanges customers in some way), then those are the values that company stands for—no matter what public image that company has created. To go beyond simply an image of being a socially responsible company requires making ethical, socially responsible decisions internally as well as publicly.

Justifying the time and the cost for developing policies that make information more accessible to the elderly is easy to do under this theory. We know that people are living longer; that the percentage of population that is elderly is increasing; and that, for the most part, the elderly are active, interested, and independent members of our society. To impede that independence by forcing them to rely on third parties to interpret information for them is to act unethically and socially irresponsibly—to act to deny these customers their much-needed independence.

Additionally, this project shows how even highly educated individuals can have difficulty comprehending the information in these two particular documents. What social responsibilities do companies have toward those customers who are less educated, less wealthy, and limited in literacy?

### **Conclusions to the Question of Ethical Responsibility**

So no matter which of these three theories along the spectrum of business ethics we consider, we can argue that writing appropriately for the elderly is the ethical thing to do. Also, housed somewhere within each of these three theories of business ethics is the argument that having inaccessible information in a policy is simply bad business. Creating documents that ignore good design principles, cognitive and physical characteristics of audiences, and user testing violates good business practices and is unethical. Explaining why such poor documents exist is difficult. Are companies simply ignorant about what it takes to create good documents or not convinced of the importance of the audience to a document? The technical communicators within companies may be the only ones with the expertise to fix the problems. Technical communicators, however, often are not very high on the company's organization chart and may have difficulty getting anyone to pay attention to what they have to say. But writers have a responsibility to the audiences of the documents they create to try. The technical communicators' code of ethics states (see Wegner 1993) that writers must recognize their responsibility to communicate technical information truthfully, clearly, and economically.

In the case of the Medigap documents tested for this project, the information may be truthful, but it certainly is not clearly and economically communicated to its intended elderly audience.

## **CHAPTER 5: IMPLICATIONS OF THIS RESEARCH PROJECT**

In this thesis I have answered my three research questions. By testing 16 elderly people using Medigap insurance policies, I have demonstrated the way in which some elderly people read and respond to documents that they are typically expected to use. Based upon several rhetorical theories, I have argued the importance of understanding and addressing audience. I relied upon some of the literature from other disciplines (i.e., gerontology, cognitive psychology, and human factors studies) and my own research to argue that the elderly can in fact be grouped together as audience (despite the limitation of using age as the single factor to define audience). Using information from the tests that I conducted, I have suggested several guidelines that technical communicators might use when writing and designing documents for an elderly audience. And, finally, citing three different theories of business ethics, I have shown that companies, and their technical writers, have an ethical responsibility to write for this audience.

But this project is not just about Medigap documents. Those documents were vehicles to answer my research questions. The results of my study draw attention to potential problems with all types of written material used by elderly readers. The elderly will increasingly become the audience for more and more of the documents created by technical communicators:

When the baby boomers reach Golden Pond, they are going to transform the image of old age. It will be a much more vigorous, active and vibrant period of life.... The boomers will be physically active and continue to work longer. We can't have 40 million people sitting around doing nothing. It's a waste.... It's not just skiing and jumping out of planes—but continuing to contribute to our society. Have you



heard about the airline pilots? They're fighting to fly past the age of 60." (Levine 2000, 73)

And this project is not about the 16 elderly participants I interviewed and tested. Those participants are educated, Caucasian, middle-class, small-town, middle-America elderly people. They represent only one small segment of the elderly population. Technical communicators must also address the more impoverished elderly, the less educated elderly, the urban elderly, and the ethnically diverse elderly. Will the guidelines recommended in Chapter 3 work for all elderly? Some will work and some will not. Technical communicators are responsible for finding out what textual and design techniques are needed when preparing documents that will be used by one or several of these elderly audiences.

So what do I hope to be the implications of this study? I hope that technical communicators, and the companies that they work for, will understand the power they hold over the elderly—power that can assist them in remaining active, independent, and productive by making information of all types accessible to them. I hope that technical communicators and their companies accept that they should make this effort either for ethical, economic, logical or efficient reasons. And I hope that technical communicators will conduct further research into how to best write and design documents for an elderly audience. And I know that readers of all ages and abilities stand to benefit as we learn more and more about writing and designing documents for the elderly.

### **Ethical Reasons for Writing for the Elderly**

Even beyond the theories of business ethics discussed in the previous chapter, I can argue other ethical reasons for understanding and writing for the elderly. In an excerpt from his book *The Virtues of Aging*, Jimmy Carter (1998) talks about the most significant predictors of successful aging. He lists what many sociologists see as the significant predictors and then adds his own ideas to the list. One consistent predictor of successful aging exists in those lists: “the degree of control that we feel we have over our own destiny” (Smith 2000, 171). We only have to remember Dutch, who admitted he would be afraid to change Medigap policies because he wouldn’t be able to verify that one was better than the other, to understand the enormous power technical communicators have to assist the elderly in “maintaining control of their own destinies.” By making information about technological changes, medical changes, programmatic changes, job changes, and so on, accessible to the elderly, we can play a major role in helping them stay in control of their own lives.

By writing and designing documents such as insurance policies appropriately for the elderly, we free them from their dependence on others to interpret those documents. And, not only do we help them stay in or regain control of their own lives, but we also increase their confidence and self esteem. From the transcripts of the interviews for this project, we see Fanwell, Pansy, Mimi, Dutch, April, and some of the others blaming themselves for not being able to answer the questions rather than blaming the documents. As evidenced by comments during the testing, Punjab and Fanwell were embarrassed that they could not find information in the documents:

Punjab: "I don't know. I'm embarrassed because I don't know." [And responds later to another question.] "This is an I.Q. test, you know. My reading five I.Q. is just firing away [laughs] just as fast as it will go."

Fanwell: "I'm not finding an answer, but it's probably a reflection on me.... Well, maybe now I'm the one that is flunking."

Certainly many other documents beyond these Medigap policies intimidate elderly readers and make them feel incapable of understanding the information. If a 30-year-old educated male reads a document and cannot make sense of it, most of us, including the 30-year-old reader, suggest that the document must be poorly written and designed. If a 79-year-old retired optometrist cannot make sense of a document, most of us, the retired optometrist included, will usually assume that "his mind is not what it used to be." But, despite the physical and cognitive changes the 79-year-old optometrist experiences, documents can be written and designed so that he can make sense of them.

### **Economic Reasons for Writing for the Elderly**

But if technical communicators or companies are not concerned about ethical reasons for researching writing for the elderly, they should be concerned about the economic reasons for doing so. I have presented statistics throughout this thesis that argue the size and importance of the elderly population. Keeping the elderly active and independent is certainly the economically prudent thing to do. *U.S. News & World Report* estimates that by the year 2050, one of every five persons in the world will be age 60 or older (Smith 2000). Supporting a growing elderly population will be much more difficult and expensive if many in that group are dependent and/or cared for in long-term care facilities.

As this older segment of the population grows faster than the younger segments, companies will have to rely more and more on an older work force to maintain productivity. Economists point out that, at our current rate, by the year 2020 we could have some 60 million “idle” people in retirement and that the U.S. simply cannot afford to have that happen (Smith 2000). Companies will have to rely somewhat upon older workers, and these older workers will be able to adjust to changes in workplace procedures, policies, techniques, and equipment only if technical communicators write and design manuals, instructions, and other informational documents with this elderly workforce in mind. And that workforce audience will be made up of diverse subgroups of the elderly population, with diversity in education levels, health status, socioeconomic positions, and cultural backgrounds. Each of those groups will require study and research by technical communicators in order to have documents appropriately designed for them.

Also, as I have suggested in this thesis, the elderly will continue to wield more and more economic power. AARP, whose large membership is made up of people over 50 years of age, is currently an organization with enormous political influence and power. The U.S. pension funds (much of which is controlled by the current elderly or soon-to-be elderly) amount to \$2.7 trillion—“...money that helps provide capital for investment in production of goods and services, everything from roads to computer software start-ups” (Smith 2000, 6). And certainly the elderly are in large numbers consumers of products that U.S. companies produce. Kay, Punjab, Louise, April, Bottle, and Charlie all were busy on their computers when I arrived to interview them, but how often do you see the computer industry targeting the elderly audience in their advertisements? And how often do technical communicators consider this audience when designing computer and

software manuals? I suspect the answers are seldom or never, despite the fact that the number of elderly product consumers is large and will continue to increase dramatically in the years to come. The oldest of the baby boomers are 55 years as I am writing this thesis. This group has often been described as “the pig in the python”—a huge demographic bulge that is moving across time. This demographic bulge will impact many aspects of our economy. Economically, then, how can technical communicators and companies continue to ignore this growing population?

### **Logical Reasons for Writing for the Elderly**

Logically, writing for the elderly makes sense because they are a definable audience and technical communicators write to specific audiences. Also, determining how to write for the elderly is a relatively easy, productive thing to do. One of the purposes of this study is not just to offer guidelines for writing for the elderly but to convince technical communicators that we can determine how to write for this audience and that it makes sense to do so. While I have presented lists of textual and design elements that would help the elderly navigate through the Medigap documents used for this test, I have not created a template for technical communicators to use for all future documents for elderly audiences. I have shown that, within the context of how, when, and why documents might be used by an elderly audience, user testing those documents is relatively easy, inexpensive, and productive. I would argue that companies and technical communicators have no logical reasons not to address the elderly as a distinct audience. However, many issues and questions remain about writing for the elderly.

### **Suggestions for Future Research**

At several points throughout my thesis I have noted ways in which designing research approaches differently or asking different questions could lead to even more information about writing appropriately for an elderly audience. In this study, participants consistently took longer to respond to questions in policy A than in policy B. Can the difference be explained by differences, for example, in sentence structure? A test designed more explicitly to see how participants comprehend information at the sentence level, not how they find the information, might explain the difference. Testing an elderly audience with two different paragraphs containing the same information but with different sentence structures could lead to more understanding of ways information is processed at the local sentence level.

In this thesis I also looked at the correlation between the participants' level of education and their percentages of correct responses. A research project that divides the groups more evenly between education levels and that includes the more marginally functioning and less educated along with the other levels of education could provide valuable information on the effects of education levels on information processing in the elderly.

Textual, spatial, and graphic design elements that were not tested specifically in this research project could be tested in carefully designed user tests, interviews, and/or questionnaires. As these examples of topics suggest, technical communicators could design tests to answer several questions:

- ◆ What specific type styles are easier for this group to use?

- ◆ Do the elderly prefer or more readily find information in numbered lists, bulleted lists, or straight text?
- ◆ How is an elderly person's comprehension helped or hindered by analogies and/or examples?
- ◆ In what ways does fatigue interfere with the processing of information in elderly readers?
- ◆ What differences in performance between elderly males and females exist when we control for education?

We might also look at what the elderly users' expectations are of different genres and how those expectations impact the way they approach documents. Did genre expectations impact John's and Charlie's preference for policy A over policy B? Will those expectations interfere with the elderly accepting more appropriately designed documents? And, certainly, we should design research that includes more socioeconomic, educational, and ethnic variety in the testing subjects.

These questions and many others remain to be answered by researchers. A great deal of interesting and valuable research remains to be done to more fully understand the elderly audience and to write appropriately for them. The presence and importance of this group has been established. I have shown that we can discover the textual approaches and designs that are helpful for an elderly audience. And, clearly writing appropriately for the elderly is the right thing to do.

## Conclusion

Rowe and Kahn, in their book on *Successful Aging*, remind us that in our culture to call something old is generally an insult. My guess is that, if asked, all of the 16 individuals I interviewed for this project and millions of other elderly would admit that they do not feel old (even 89-year-old DeeDee). What they would be saying is that they do not feel like they fit the stereotypes our culture maintains of an old person. Does Dottie fit those stereotypes—receiving a grant from a major drug company to write and publish cookbooks, using state-of-the-art software to create those cookbooks, and selling those cookbooks over the Web—at the age of 78? Does Fanwell fit those stereotypes—researching, writing, and publishing books and newspaper articles—at the age of 90? And does Punjab fit those stereotypes—admitting his developing skills at working on his computer and using other new and interesting technological devices—at the age of 79?

As technical communicators, we have to begin to look beyond and work to change cultural stereotypes. We need to research writing for the elderly in all areas to discover who the elderly really are and how they read and respond to documents they are expected or need to use. We must do it not only for economic and rational reasons but for ethical reasons as well. We are ethically responsible as creators of documents to do what we can to allow Mimi to continue “trying new things,” to allow Dottie to continue developing her growing business, and to allow Fanwell to continue to share his wisdom with the rest of the world.



## **APPENDIX A. TRANSCRIPTS**

## Pre-test Questions

Participant: Sydney

Age: 66

March 2, 2001 at 1:30

Q: What are your hobbies, if you have time for hobbies?

A: I like to cook and bake. And I also have been making quilts. I do fancy embroidery and that kind of thing.

Q: Do you travel?

A: Not so much. I was just home from two weeks in Lincoln with a daughter. And I go to Rochester to visit a daughter up there. Sometimes we do brief trips, but it's a real hassel.

Q: So mostly you travel to see family?

A: Right.

Q: Do you read, play cards, or anything like that?

A: Yes. I read, I do crossword puzzles. I'm not much of a card player or a board game—especially the board games that are chance. I don't like those. I like board games, something like Scrabble or Trivial Pursuit--something where you have to have a little knowledge. That I can handle.

Q: How about exercise? I know you have some sort of breathing problem.

A: Yes, I do have some, but I walk around the house and I go visit neighbors. You know, I can walk short periods. On really good days I can do more. I just have to pace myself. I can't clean house, do major baking, and go to the store all in one day. I have to pace it.

Q: How about volunteer work, do you do any volunteer work?

A: No, I haven't gotten into that yet, we just moved here in July. And I'm hoping to put my name in at ACCESS, because with my background I'd really much like to work there or Youth and Shelter Service.

Q: How about newspapers? Do you read newspapers or watch TV regularly?

A: Yes, we do and we watch specific programs on television. We watch the ball games and stuff like that. Yes, Iowa State fans. Both Becky [her daughter] and I graduated from Iowa State.

Q: Are you a member of any clubs or organizations?

A: No, I'm not much of a joiner.

Q: And you got your degree at Iowa State. What kind of work did you do?

A: Okay, I was a non-traditional student. I got a degree in, I think it was, '93 and I worked for one year as a social worker at Winneshek County Hospital up in Decorah and then my health deteriorated and I wasn't able to do any more. I worked as a nurse for over 30 years. I graduated from Iowa Lutheran Hospital School of Nursing in '52.

Q: Just a few more questions. What about your eyesight—do you read large print?

A: No, I can read large print, of course. But I had two cataracts removed and my vision now is normal.

Q: No macular degeneration or glaucoma or any problems like that?

A: No, no. I have no excuse.

Q: So you can read newspapers and things like that?

A: Right, right.

Q: Does Becky [her daughter] live here with you?

A: I live with her. She owns the house and I pull my weight by keeping the house, decorating, and running errands, and doing phone calls—scheduling appointments. Combination social secretary/housekeeper.

Q: Do you still drive?

A: Yes, not long distances because I get too tired. It isn't that I can't drive to Des Moines or even up to Rochester, but I would have to stop half way and spend the night someplace to sleep because I just don't have the strength.

Q: Would you mind telling me what your health problem is?

A: I have mitral valve stenosis with atrial fib.

Q: I'm a registered nurse so that makes sense.

A: I am too. I was a nurse and I wrecked my back and that's why I went back to school to become a social worker.

Q: So you worked several years as a registered nurse?

A: I was...over 30. I graduated from Iowa Lutheran Hospital School of Nursing in '52.

Q: So you have mitral valve....?

A: Mitral valve stenosis with atrial fib. I also have chronic bronchial asthma and diabetes—type II. Still, I'm better off than the rest of my family.

Q: Are you on pills for the diabetes?

A: Yes, I take hypoglycemic pills.

Q: Are you on medication for your heart?

A: Yes, I take Lanoxin, Cardizem, and I also have to take Coumadin—according to my pro time. And then I take Evista because when I am hospitalized they put me on Prednisone. Evista is supposed to increase my bone density. I take those and I take Zantac because of all the medicine I take upsets my stomach.

Q: What do you do for your breathing?

A: I take nebulizer treatments every 4 hours for breathing and I use oxygen at night.

Q: Only at night, you haven't had to use it during the day?

A: Just at night. Well, sometimes I've had to after a hospitalization. I really hate dragging that tube around. I step on it and about lose my head. So I don't think its helping me much. They finally got all of my meds regulated to the point where it keeps me out of the hospital. I have—knock on wood—I have been a year now without being hospitalized. Usually they hospitalize me for congestive heart failure.

Test #1: Policy B

Questions: A, B, and C

Question A answer: Well, this print at least is easier to read than some that I have seen.

This seems to be fairly easy to scan, you know. So far all I have seen is out of state services—nothing for out of country. These are hospitalizations. I still don't see anything about out of country. Everything I see is out of state or.... Okay, Medically Necessary Emergency Care in Foreign Countries. [Note: Sydney was reading headings as she scanned the document starting at the beginning looking for this section] Pay 80% of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and care....subject to the calendar year deductible of \$250? I thought the deductible on this was 500. No, that's on the Medicare. Yes, Medicare—it's \$500. Lifetime maximum benefit 50,000. Boy, that's not very much. So it is covered and it is clearly explained. I thought.

Question B: I saw that back here a little ways. It was on one of the first pages. [Note:

Sydney is looking at headings as she moves back to the front.] You don't need to file a claim by Medicare for any service. By law, physicians or other suppliers must fill out the claim forms for you to send them to Medicare even if they do not accept assignment. You should always make sure your providers know that you have supplemental coverage with us. When you receive health services in your home state, Medicare will automatically send your claim to us. So you don't have to worry about it as long as your physician knows that you have this policy. This was really very well written. Very easy to read. Very well divided and I think even someone with some vision problems could follow it.

Question C: [Note: Sydney moved through the pages quickly scanning. Did not indicate

what she was looking at.] We have the right to change your premium upon our implementation of a new table of rates, an increase in your age, or a change in Medicare's benefits. If we do not change your premium, we will notify—oh, if we do change your premium, we will notify you at least 30 days before the change. I suppose once a year they do an implementation of a new table of rates, and it can also be cancelled if your fraudulently misrepresent or conceal facts in your application, fail to pay your monthly premium or terminate this policy giving written notice. Then it goes on with the effects of the termination—what they don't pay then. It was very clearly written in, what do I want to say, lay language.

Post-test interview for Policy B:

Q: That's what I was going to ask—one of the questions I was going to ask was what parts of the document was helpful. You say the laymen's language?

A: No, I think that anyone that reads through this... know my mother's policy, you would just tear your hair.

Q: Were there any aspects of it that caused you any trouble as you went through?

A: I don't think so. I figured that policy information would be towards the back and services not covered and then your benefits are clearly.

Q: Are you saying that you found things where you thought they would be?

A: Yea, yea. And I didn't really have to go through everything that was written to find the information that we were seeking.

Q: Did you find any parts that were confusing?

A: No, not to me I didn't. I thought it was fairly, you know, straightforward. Not a lot of legalese or wherefors and therefors and so forth.

Q: Do you have any suggestions for how to improve this document?

A: No, no. I think this is fine. It's a good size. The print is big enough for even people with problems to read.

Q: So the size of the document itself is good?

A: Right, right. And it is clearly outlined so that, you know, *When Coverage Ends*...this kind of thing. You know, you just flip through and see the bold print. So, I thought it was very good.

Test #2: Policy A

Questions: D, E, and F

Question D: Well, this one is not going to be as easy, is it? [Note: Sydney is scanning

through pages and mumbling as reading.] Let's see—insures against most of the gaps in Medicare for a sickness. [Note: Sydney is reading from unbolded text in first section of page 2.] How to file a claim. [Note: reading from large heading middle of page 2.] Boy, this is much more difficult. "We will pay you for Medicare eligible expenses..." [Note: reading from text under Agreement. Scanned page more and then looked at definitions. Read all of the following from definitions. Did not go beyond definitions.] Definitions of you and your...benefit period...Medicare eligible expenses. Okay, finally, Medicare considers unreasonable, unnecessary or in excess of the Medicare legal limiting charge is not...no, that's not it. This is the amount of Medicare eligible expenses you must pay each calendar year before benefits can be paid under part B. You meet the deductible only once in the calendar year. So I assume that that means that you have to pay the Medicare deductible before these start. This is much more difficult.

Q: Is that for Medicare part A or part B?

A: It says, okay...you must pay each calendar year before benefits can be paid under Part B. So it must be part A.

Q: How about part B? [Note: continues to read from definitions.]

A: Well, it just says that you have to pay the deductible before benefits can be paid under Part B. Maybe they pay under Part B and not under Part A. That's confusing. That's very bad. Okay.

Question E: [Note: Sydney stayed on the same page from last question. Looked down the page to the correct section on that same page. Went to the section right away and started reading.] We will pay the actual billed charges up to the coinsurance amount—oh, this makes no sense—from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A. Lets see, we pay the actual billed charges up to the coinsurance amount. I don't know what the coinsurance amount is and I don't see a definition for it. [Note: looked up in definition section.] I really don't [Note: continues to read.] ...this makes no sense. This has nothing to do with what I was just talking about. This particular...I was looking for some more information on what the coinsurance was. [Turned the page and reading from the next section following the section on skilled nursing.] Benefits are payable as follows: "When Medicare pays for Part B services and supplies, we will pay the calendar year deductible"

Q: Is that for skilled nursing?

A: No. And...pay the calendar year deductible and pay 20% of your Medicare eligible expenses incurred for those Medicare Part B services and supplies and...this, makes no sense. [Note: rereading Section B.] Benefits to supplement Medicare Part B. Benefits are payable for part B services and supplies, we will pay the calendar year deductible—it said here you had to pay it. That must be for part A. [Note: reading now again from the definitions.] Calendar year deductible

the amount Medicare eligible expenses you must pay each calendar year before benefits can be paid under Part B. But if you meet the calendar year deductible, that's a flat amount—whether it's A or B. So what in the heck is this? Here's that and here's this—calendar year deductible. [Note: comparing section B and definition section.] It makes no sense, does it?

Q: Any clue then as to how you might answer that or if you were in this situation, what coverage you would have?

A: Umm, alright, expenses not covered by this policy... [Note: reading under *Exclusions and Limitations*] ...no benefits are provided for skilled nursing care above the number of days covered by Medicare. So if Medicare covers 20 then that's all this covers? [Note: goes back to section A.] But back here under skilled nursing it said, we will pay the actual bill charged up to the coinsurance amount from the 21<sup>st</sup> day to the 100<sup>th</sup> day. Okay, the coinsurance amount? So that means they would pay what Medicare paid? Right? Isn't that the way you understand it? We will pay the actual billed charges up to the coinsurance amount. And coinsurance is Medicare...from the 21<sup>st</sup> day through the 100<sup>th</sup> day. So you've still got 20 days that you have to pay on your own...if you're in for 120 days. Right? That's the way I read it. This is poorly written for someone who does...who has no clue. I did UR so I have some clue about it, but...(laughs). We just had our little book that we looked up to see whether it covered.

Question F: [Note: scanning the pages from page 3 forward.] We will pay for care received in a foreign country as follows... [Note: reading from section C.] I mean I thought that was the whole idea of supplemental was to cover the...well, maybe not. It does not...I don't see anything about it. [Note: just scans quickly through pages.] It does not...I don't see anything about it. They won't pay that I can see. I guess I would take the 800 number and use it as much as possible. It doesn't say anywhere. Not that I can find...just on...you know scanning through it...anything about ...psychiatric care, lifetime amounts, blood transfusions, skilled nursing care...a stay in the hospital. It has a wonderful set of definitions. Um, it doesn't say anywhere that it pays anything on hospital...or doctor...office calls. [Note: two minute break as she answered the telephone.]

Q: Then, so we just accept it then that the information wasn't in there?

A: Not for me.

Post-test Interview for Policy A:

Q: Where in this document did you think you were having trouble?

A: Okay, well I think the big problem is that I say the other one first. And it was...because you know that was so easy to look through and this does not seem to be...well...in the first place, it doesn't seem to be divided, to me, very logically. You know, I would like to see "How to File a Claim"...no, before to file a claim I

would like to see it written out what this insurance covers. What this insurance does not cover.

Q: So the headings should be more specific?

A: Right. How to file a claim. How to argue a decision, you know. What the cost is. I said cost should be on the first page. And then the things that would have to do with exclusion, and the things that have to do with whether they can do...cancel the policy or delete you from their system or whatever.

Q: So you would like to see the headings more clearly indicate what is actually in the part?

A: Right, right. And, you know, Payments of Claim. Okay, they've got a half of page of Payment of claim. It makes no sense. [Note: reads the section on notice of claim.] Okay, they could cut that down into about four words. You know, cut a lot of this out. You know, it's—okay, it says if **your** residence is no longer Iowa and **you** move to a different...these we, you, you, we are all dark print.

Q: Is that good or bad?

A: Well, we know who you...I think it would be far better to have it...and I noticed they dark printed all the Medicare, everything that says Medicare. See, this is...you know, if you're scanning you look for dark print thinking that would be more important and...**are we, you, they**. I don't see a reason to do that and I don't see a reason why Medicare has to be bold-faced.

Q: So it doesn't help any, does it hinder at all?

A: It does, because your eyes are drawn to those and you don't read the words that are important. [Note: read another section.] You know, the stress is in the wrong place. I think.

Q: So you would like to see different type headings, shorter sentences and bold what is really important to the user?

A: Right. You know instead of renewability, they could put guaranteed renewable in bold print. And then put "...for life subject to our..."

Q: Are there any parts of this document that are helpful? Are there any areas that they did do well?

A: They did...okay. They tell you how to file your claim and that is fairly simple. And doesn't have a lot of bold printing. And has questions so you can call the agent or whatever—which is nice to have that readily available. And, here again, they are doing the **we, you, your, you**. And it draws you eye instead of to what you... The one thing I thought they did do very well is they would do emergency care needed immediately because of an injury or unexpected illness. They covered that. A lot of it I think is just not written for the regular person to understand. I mean, I worked for utilization review and I'm having trouble understanding. And the exclusions are pretty clear. They did the exclusions and limitations...and then



the emergency care in a foreign country. That tells you what...better than the others. And this proof of loss I don't understand. If this is from the page before they should work to put it on the same page. Because they are going to wonder what in the world....general physicians, entire contract changes. [Note: reading document out loud.] Grace period. Renewability. If you become eligible under Title XIX of.... [Note: reading from a section.] Well, that makes sense because you get better coverage under Title XIX overall than you do under Medicare.

Q: Well, how would you overall compare the two documents?

A: Okay, I found the second document to be more difficult partly because it was paper stapled, whereas the other was a booklet. I found that the use of the bold print detracted from my ability to find the information I wanted when I wanted it. The titles on some of these [in policy A] are not quite as good. [

Q: So you felt that this was good on the first document?

A: Yes, yes. They do have a definition thing. And that's fine, but, I think, most people know what you or your—means the name of the insured.

Q: So, you don't think they picked the right things to define?

A: Yea, see...right. I think they would be better off to maybe list a sub-index or something before the benefits and say, you know, we will pay 80% of this, we will pay anything Medicare does not cover, we will not pay if Medicare doesn't pay. We will pay or not pay like for my oxygen condenser or my pulmonade, or anything like that, will they pay for that? See?

Q: So spell that out more clearly?

A: Yea, yea, instead of all of this, you know, calendar year and all this kind of stuff. Most people understand that their coverage is from when they took out the policy until they have to take it out again. And, I think, a lot of it was extraneous. And some of their...okay blood transfusion [Note: read this section.] Well, if you or a member or your family has this policy and you have to have three units of blood you're probably not going to be able to read this print. You know. And I think that's another thing. It could be perhaps just a tad bit bigger. I don't have any problem with it. But, you know, you look at 4 pages, closely typed and people are going to say I'm not reading that. If they don't cover it, they don't cover it. You know, you're just not going to want...they want to know. What they'll do is they'll take it in when they go to the doctor or when they go to the hospital and say here's my policy, does it cover everything I need.

Q: So you think with this policy, people are just not going to look at it?

A: I don't think they'll look at it because it is not set up for them to understand.

Q: How about this one---policy B?

A: Yes, I think people will refer to this because the print is bigger. It's well laid out. It's a book. You can just flip through it. Whereas this you've got to pull it up,

you've got to fold it under, and it flips out of the way and then you have to go back and read something. It's not laid out very good because if this... it says *Section A Benefits*, well this is section B... it is payment of claim. All of the payment of claim information isn't together.

Q: It should be on the same page?

A: Right. Yea, yea, because if it isn't, people are going to read this and they are not going to look on the next page to see what it says. And the way this is written I'm not real sure... I'm sure that it is what—that's what it is, but it doesn't say payment of claims continued. Because you know I was reading that and I thought this makes no sense and I think that's.

Q: So at least it should have something that indicates that is the same section?

A: Right, right, of this heading You know, general considerations, general provisions. Okay, here is some more where they didn't put continued. But I really think a booklet, somehow a booklet makes people think that it is more important... You see this [policy B] covers essentially the same thing, but it covers... you know, and if you have to call somebody and make notes, you've got room here.

Q: So a lot of white space is good?

A: Yeah, yeah. And I think a booklet instead of like this.

Q: Do you have a Medicare Supplemental Policy?

A: No, I'm on Title XIX.

Q: Do you have documents you refer to?

A: No, it's pretty well explained. It doesn't cover, you know if I figured I needed a face lift it wouldn't cover that. But anything that can be proved necessary—it covers my oxygen condenser, it covers the cost of my pulmonade.

Q: How did you know that? How did you find out?

A: What it covers? I went to human services and you know told them that I wasn't able to work. Actually I was on disability so I got Medicare when I was 62 and then I knew it from working UR. And I just asked them and they told me that yes, it covered what Medicare covered. And it covers... the reason I'm on it is because of my meds. I run about \$6,000 a year in meds.

Q: So if you had a question, if something new came up and you weren't sure, how would you find out?

A: I would probably call Medicare if it was enduring equipment. I would probably call Medicare to see... Anything like that, I check because Medicare is my primary. And then if they didn't pay then I would check to see if Title XIX would. They might pay part.

## Pre-Test Questions

Participant: Kay

Age: 69

March 7, 2001 at 3:00 p.m.

Q: What are your hobbies? Do you travel? Read? Play cards?

A: Oh, I love crossword puzzles and board games, jigsaw puzzles. We play lots of board games: Trivial Pursuit, Millionaire, Clue. And I like computer games—I'm not really into computers but I can get it on enough to play games.

Q: Do you read?

A: Yes, I like to read. I like historical novels.

Q: How about exercise? Are you able to exercise?

A: Oh, I don't do as much as I should. I should walk more, but not this winter. I'm not a mall walker. I should be, but I haven't started.

Q: Do you do any volunteer work or serve on any committees?

A: No, I do not.

Q: Do you read any newspapers?

A: I read the Des Moines Register and the Ames Tribune every day.

Q: Do you watch TV?

A: We do watch TV in the evening. I like "Judging Amy." I love that show. I just love Tyne Daley. And ER—that type of thing. I like Larry King. We watch him quite a bit.

Q: You're not working now? Are you retired? What kind of work did you do before you retired?

A: I had worked in an insurance agency. That was many years ago. And I worked for a year and a half or two years in a driver's license station. Other than that I've been a homemaker. I raised four children. I have three that live here in Ames and one in Des Moines.

Q: So you don't have to travel to far to see them?

A: No. In fact my daughter and granddaughter live with me. And so I take care of Chelsea and get her to dance and here and there.

Q: You drive then?

A: Yes, I drive.

Q: How about your vision?

A: It's fine. Well, I need glasses, of course. No problems.

Q: No cataracts, no glaucoma, or macular degeneration?

A: No, no.

Q: So you don't need large print to read?

A: No, I don't at all.

Q: How would you describe your health overall?

A: I have always been in good health. Well, I have a thyroid problem but with medication it's okay.

Q: Other than that you've been pretty healthy?

A: Yes.

Test #1: Policy A

Questions: A, B, and C

Question A: [Note: looks at TOC and then scans the first 3 pages very quickly.] Okay. Okay, let's see, if I'm out of the country and need—let's see. Okay. Emergency care in a foreign country. They will pay for the care received. You pay a deductible of 250 and they pay 80% of the billed charges for Medicare—that would have been covered by Medicare provided in the United States.

Q: So then they do cover it?

A: Yes.

Question B: Okay. Let's see those are benefits. [Note: starts by looking on page 3.] That wouldn't be it. [Note: looks back at Benefits on page 3 and then scans down page 4 to Payment of Claims section.] In this policy you have to provide them with a written notice of the claim. And it must identify you and your policy number. They receive the claim, they send you the forms. That's the way I understand it. Then the benefits would be paid to me unless they had been assigned to a doctor or hospital. You send them forms for proof of loss. Let's see, it says that the proof of loss would include proof of payment made by Medicare. It says benefits will be paid promptly upon receipt of proof of loss and paid to you unless it's assigned to a doctor or a hospital.

Question C: [Note: looks at the TOC before going to the section.] Let's see, renewability. This policy is guaranteed renewable for life subject to their rights to change the rates and subject to you remaining an Iowa resident. It cannot be cancelled or nonrenewed by us on the grounds of deterioration of your health. But they can change the rate. Your renewal premium may be changed if we change

the premium for all policies of this form and class in the state where you live. Or in changes in policy benefits. And your rates increase yearly on the first renewal date following your birthday.

Post-test Interview for Policy A:

- Q: Did you think that there was any part of this document that gave you trouble?
- A: Well, I think mainly the filing of the claim would be my big concern. As I understand this you have to file your own claim. And I think with my supplemental form they file it through the doctor's office. As I understand this policy.
- Q: Was that confusing, did you think?
- A: Yeah, it was a little bit confusing—that part of it. Maybe not as much confusing as making it harder for the patient.
- Q: Were any parts of this document, the way it was designed or written, that was helpful in finding information?
- A: Well, I think the first page of the document, if you follow that, you can go to the place where you need to go
- Q: Do you have any suggestions for how it might be better?
- A: No, I can't really think of anything.

Test #2: Policy B

Questions: D, E, and F

Question D: [Note: starts by looking at the TOC.] Okay. Let's see, that's on page 3. For Medicare part A. [Note: flips back and forth between 3 and page 1.] I don't see the deductible. Maybe I'm looking on the wrong page here. [Note: looks back at TOC and then back to page 3.] I just cannot find that. Medicare deductible for Medicare part A. I don't see that or I can't find it. [Laughs.]

Question E: Okay, I think I just read something about that. [Note: scans through pages—does not look at the TOC.] Now I found the part on the Medicare part A deductible. They pay all of the deductible for a benefit period. And for skilled nursing they pay for the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for skilled nursing facility. I found the, yes, the answer to the last one. I was on the wrong page for that.

Question F: [Note: reads information on the same page where left off with the last question.] The Medicare part B would be your doctor's visit. And, they pay all of the Medicare part B deductible amount for calendar year. They pay the difference between the actual Medicare Part B charge as billed. I don't know whether I can find anything else on that or not.

Q: How did you know that Medicare part B is doctor's office visits? Is that in here?

A: I just knew that I guess. Yes, it does help pay that and it pays...part A and then part B deductible. And then it says we pay all the difference between the actual Medicare charge as billed and the Medicare-approved part B. So they pay the difference.

Post-test Interview Policy B:

Q: Was there anywhere in this document that you feel you were having trouble?

A: I think it was maybe a little harder to understand. Or to find what I needed maybe. I don't think they set out where to look for things. Like an index. That would help a little. The other policy it did.

Q: It has that front part but it really didn't guide you very well?

A: I guess I did see that. I guess I sort of by-passed that. Just about everything you needed was on one page—on page 3.

Q: Were any parts of the document confusing?

A: No, not really. I guess.

Q: Any parts that were particularly helpful? Anything about the way this document was designed that was helpful?

A: I don't think it was as clear as the other policy.

Q: So if you compare these two documents?

A: I think the first document [policy A] was easier to understand.

Q: Do you have any suggestions for how to this document could be better?

A: I think the way they word things. They could maybe make it simpler.

Q: Do you have a Medicare Supplemental Policy?

A: Yes, I do.

Q: Do you ever refer to it when you have a medical claim?

A: I did when I first got it and if they send amendments to it I read that.

Q: So if you have to go to the doctor or have something going on, what do you do?

A: I know pretty much what it covers and of course I talked to the insurance agent thoroughly about it.

Q: So between the document and the agent...

A: Yes, I pretty much know. [Her policy is not one of the test policies]

**Pre-Test Participant Questions****Name: Mimi****Age: 72****March 15, 2001 at 1:00**

**Q:** What are your hobbies? What kind of things do you do in your spare time? Play cards? Travel?

**A:** I guess I am probably a jack of all trades. Because I've done...I do lots of things. I love to read. I love to garden. I knit. I refinish woodwork—furniture. I built a dollhouse to scale, an inch to a foot. I am pretty game at tackling most anything. I think...I may not do it real well, but I will tackle most anything. [

**Q:** Do you exercise?

**A:** Yes, I have one of those exercise balls. So I do exercise. Maybe not as faithfully as I should.

**Q:** Do you travel?

**A:** Yes, we do. We try to see our children at least once a year. Our children are scattered—one in California, one in Boston, one in Kentucky and we have one in Ankeny. We try to get to see the children. And we try—we've made trips to Florida. We're not fond of Florida like a lot of people are.

**Q:** Do you read the newspaper daily or watch TV regularly?

**A:** I do read the Ames paper. The obituaries, of course, to see if my name is on it. We watch television in the evening, if something is on. Really we watch the educational channel more than any other channel. We're not big TV watchers.

**Q:** How about any clubs or organizations, do you belong to any?

**A:** Yes, I belong to PEO. I'm taking this course in the Bible. It's called...Bible study...my goodness, I can't remember right now (I'm having one of those senior moments). It's a class that's really like taking a college class in the Bible. I'm taking that right now. I'm not active in the church like I used to be. That's about it.

**Q:** Any volunteer work?

**A:** No, I do not at this time do volunteer work, except taking chicken soup to sick people.

**Q:** So you were a dental assistant?

**A:** Yes. Well, yes, I was an optometric assistant. I worked for Dr. M. at that time. He's retired. I was a certified optometric. Then I became a dental assistant for Dr. Joe.



Q: Do you stay connected to those professions in any way?

A: No, no.

Q: How about your vision?

A: Vision's great. I did have cataract surgery and it's a miracle—absolute miracle. Couldn't believe how bright everything looked afterwards.

Q: So you don't need large print to read?

A: No, I ..well, of course, I need glasses to read.

Q: You don't have any problems seeing basketball scores or print on the TV?

A: No, no.

Q: You don't have glaucoma or macular degeneration or other eye problems?

A: No, I have no problems.

Q: Do you still drive?

A: Oh, yes.

Q: How would you describe your general health?

A: My general health is fine. I have high blood pressure and that's probably the one thing that—and I think—some of it is I've gained quite a bit of weight since I stopped working. And that hasn't helped. And part of it is my husband is retired. [Laughed.] And my mother had high blood pressure. And I do take medicine for it.

Q: That's basically the only health problem?

A: That I know of. I guess we really don't know what's going on inside but as far as the doctor is concerned, that's the only thing.

Test #1: Policy B

Questions: D, E. and F

Question D: Are you going to give me a chance to go through this first? [Comment: Just go through it with that question in mind.] You want the deductible for Medicare Part A. [Comment: And then also Part B.] I know the answer, but do you want me to look it up in here? Well, it's on page one. It says it right here in the beginning. It says part A, part B.

Q: Does it tell about the deductible?

A: Oh, okay, I don't see the \$100 deductible. [Note: reads through the first and second pages.] I don't see the deductible. It has to say \$100 deductible. [Note: reading from page 1.] All right this is really talking about...this is talking about if you have a physician that accepts the Medicare charge as is...and they will pay the

difference. But if there is not...I do not see here about the \$100 deductible. Now whether that is in another part of this...because you have to...that's with Medicare...not this insurance. Yes, because this insurance policy will pick up the \$100 deductible but Medicare will not. Right, it doesn't say \$100, but you have to pay that first \$100 and then the insurance policy will kick back that \$100. Well, that took a long time to figure it out.

Question E: Okay. Well this is Medicare part A. [Note: remains on page 1.] Is Part A hospitalization under Medicare? Part B...how did that go. We have part B. [Note: scans and then stops on page 4 and reads information.] Well, here they are saying there is a limit to how many days of hospital nursing facility that they will pay for however you can renew a benefit period. And renewing a benefit period means that you can get a new benefit period all over again. That's for 90 days. If you are in the hospital for 90 days. Benefit period ends after you have been out of the facility for 60 days in a row. That has to be after you are discharged. [Note: reading slowly down page 4.] That's while you're in the hospital. Okay, this...I don't think that's the question though. I think I'm answering the wrong thing. After you have been out of the hospital after a period of time that's when you renew a benefit period.

Q: But they're talking more about a hospital?

A: Yea, they sure are. Okay, here we are. This is 90 days. You've got 120 days. Okay this tells me that they are going to cover me what Medicare doesn't pay and it says my Handbook will give me an explanation of the reserve days. [Note: continues to read from wrong section on page 4.] But they will cover what Medicare doesn't pay. but that is a simple answer. I went way around the bush.

Q: So it's your understanding then that they will cover it then?

A: After...yea, after...what Medicare doesn't.

Question F: And I'm to look in here? Okay...that's hospital. We want doctors. [Note: reads and scans page by page and going back and forth in the document.] Okay, they will not pay any services that are denied by Medicare. Or they won't pay for the duplicate Medicare coverage. They will pay for doctor's office visits. They will not pay for physicals.

Q: Is that's just something you know? [Note: Is actually reading from Services Not Covered.]

A: That's something I know (laughing) I didn't see it here. I know that. I really didn't see...I would have to stop and really. That's hospital...this is nursing facility...it doesn't say doctor...foreign country. That's blood. [Note: Goes back and forth through pages reading mainly headings.] That's benefits...this just tells me what they won't allow benefits for. Is this as far as this goes? ...premium...that just tells me...here's the deductible. One nice thing about McFarland Clinic down here is they do all the paper work. Now that can be a

bummer for older people. No, I do not see anything in here that says specifically about my doctor's office calls.

Post-test Interview: Policy B

Q: Anyplace in this document did you feel you were having trouble? Or you felt was confusing?

A: Confusing? Well, [laughs]...it doesn't take much. No, I think if you are looking for specific things...ah...I have to sit down myself and go over this line by line to concentrate on it completely.

Q: Well, just looking at it, does it seem to be organized in a way that would be easy to find information?

A: Yes, I think so.

Q: Any parts of the way it is designed that are particularly helpful?

A: It really has the headlines that tells you the way the page...the filing, it has the benefit period.

Q: So the headings and the way it's broken up into sections are good?

A: I think it's fine.

Q: Do you have any suggestions as to how it could be better?

A: No, I don't. I'm not that versed...

Q: Do you have a Medicare Supplemental Policy?

A: I think it's [the same company]. We have B and I think it's the F policy. You can't afford not to have a supplement.

Q: Do you ever refer to it?

A: McFarland Clinic and the hospital know that we have a supplemental policy. So we don't have to worry about it.

Test #2: Policy A

Questions: A, B, and C

Question A: [Note: reads carefully down the 1<sup>st</sup> page and then to the 2<sup>nd</sup>.] Oh, boy. I'm trying to find where it has the out of country. Oh, here...maybe...no. [Note: reading to self. Looked at the TOC.] Sorry, I don't see anything here on the front page for out of country. There is quite a difference between traveling out of the country and what they will cover in the country. [Note: going through pages very slowly. Reads down page 3 headings before turning to page 4.] I don't see any out of country. Maybe it's under the heading of one...I don't see it under the headings...I really don't see out of country. Let me look here. Okay, here we are.

I just needed to turn the page. It's section C—*Emergency care in a foreign country*. First you pay calendar year deductible of 250 and then they pay 80% of Medicare eligible expenses. That's 80 percent.

Q: So, they do cover it?

A: 80 percent.

Question B: Okay. Ah, you have to have a written notice of a claim. [Note: looks down at the bottom of page she was on from the last question.] You have to have your policy number. That is...that payment...I assume that that payment...well, it says payment of claims. Also, the payment will be paid to you unless you've designated you want them to pay the doctor. They will send you the forms. You have to make out the forms and send them in.

Question C: [Note: looks at next section. Read from *Entire Contract Changes*.] Okay. that's changing...it says here that no agent may change or waiver any of the contract provisions, but we're looking here for the premium costs. [Note: scans slowly down that section of *General Provisions*] It can be changed because it would have to be approved by one of their officers. What they will cover can be changed. That's if you don't pay it...you have a grace period. And then they will reinstate it. [Note: continues reading down sections under *General Provisions*] This policy is guaranteed renewable for life subject to our rights to change rates and subject to you remaining an Iowa resident.

Q: They have the right to change it then?

A: Yes, apparently. They won't renew your policy at all if you're not a resident of Iowa. Well, that's in any state that they're not licensed in. [Note: continues reading down this section.] No, I guess I don't see it. Only that. Now that's just going through it quickly, but I do not see where it states other than that statement.

Post-test Interview: Policy A:

Q: Was there any place in this document that you felt you were having trouble?

A: No. No, it tells you, it tells you what it's going to pay.

Q: Any part of this that was particularly helpful?

A: Well, I suppose, having seen another one..I think as far as the print and the outlay of the material it's not as conducive to me as the first one was.

Q: That was another question. Can you compare them and contrast them? What in particular, the size...

A: Probably the size, the way it's laid out—categorized I suppose you would say.

Q: Anything else?

A: No, they both tell you what they are going to do and what they cover. The information is great. I think the information is great.

Q: Any suggestions as to how they might be a little bit better?

A: I don't have knowledge of that (design) area.

Q: So if you were going to use that document, you would be able to find information in there?

A: Yes.

## Pre-Test Participant Questions.

Name: Charlie

Age: 74 y/o

March 15, 2001 at 2:00

Q: What are your hobbies? What do you like to do?

A: Well, I'm a reader. I like the computer. And I have about—right now in my mind I have about five books laid out to write. And the first one I have a stack of about a foot or foot and a half of history obtained. So now I bought a super duper bigger computer. My was an 11 year old Gateway and it just didn't have the capacity. And so I am going to start—in about five days I'll start putting that all together.

Q: What is the topic?

A: It's historical from 1860 to 1960, told by one person who lives to be 100. So you get all the progress that has passed from 1860 to 1960.

Q: Do you travel? Do you play cards?

A: We travel—like we ran up to Door county before the winter heavy set in. We run down to Texas where we have a grandson and grand daughter-in-law. And we have friends in Colorado. And of course we have one son working in LA and one in Boston, one in Kentucky and one here in Ankeny. And we motored down to Buloxi. Tried the new...they just had opened the casino and we had three nights. We pick up little tidbits. It's a little looser. Donald Trump makes it a little looser when its new. Then we went on over to Mobile and on over.

Q: Do you exercise?

A: Yea, I try to and of course doing yard work and doing most "to-dos's" that husbands are assigned. I get plenty of exercise. I have no problem with that.

Q: You said you are a reader, do you read the newspapers everyday?

A: Newspapers, magazines, books.

Q: Are you a TV watcher?

A: In the evenings if it is something good on. We do not have cable yet. Unless there is something really interesting to watch, well then we don't.

Q: Are you a member of and active in any clubs or organizations or do you serve on any committees (such as church committees)?

A: I had so many in the past. I was—we're Lutherans down here at St. Paul. I was an elder for three different terms, three years a term. I was a scout leader. I was a life scout so when we moved back from the coast I became an assistant district commissioner. And we opened up [a camp] every spring and closed it up every

fall. And our four sons were active in scouts. Let's see, social...I used to be on a lot of committees...political party.

Q: Are you still active politically?

A: We're retired from that too. We give our own opinion but it stays pretty much inside the walls.

Q: You and I talked earlier about the kind of work that you did. You've had a lot of experiences. You taught in engineering at Iowa State and also had your own business?

A: I taught engineering and business at Iowa State. I had my own business. I had three companies that I formed. One was engineering Boatman Industrial Services Incorp. The other was procuring people and personnel. Working with companies you run into what they needed. So I developed—here's my other hat—so I found a lot of people jobs. I found out I could turn a meter on while I was doing that and they didn't mind. Then the third one I was a member of the International Platform Assoc. nationally. I was a charter member of that out of New York City. And I got my senior consulting stamp of approval from that. And that was like the old chatauqua—now they call it the International Platform Association. That was back in Washington D.C. I helped start that... [talked several more minutes about this.]

Q: Do you stay connected in any way to your former professions?

A: Not really. Well, I stay connected to some of my clients. I have a flooring company out of Pella that has three corporations and I'm on the phone with them. For the first year or year and a half we went to their quarterly meetings. They have family.....they are turned it over to kids and now they are turning it over to grandchildren. They call and we get together for dinner in Pella or Des Moines or here in Ames and get brought up to date on it... But it's fun. Then I have some...over in Cedar Rapids I worked for Cedar Rapids Incorporated which is owned by Raytheon. I worked on missiles...Desert Storm.....When you get into consulting you learn never to turn a job down. [Talked a little more about his past work]

Q: I notice you don't wear glasses.

A: I do for driving.

Q: So your vision is good?

A: Yes. Otherwise I can read and see the TV and read without glasses.

Q: So no glaucoma, macular degeneration or other eye problems?

A: No.

Q: Do you have cataracts?

A: No, not yet. I can't afford them.

Q: So you don't need large print to read?

A: No, I can read that so far.

Q: And you still drive?

A: Yes.

Q: How would you describe your general health?

A: I think it's excellent. You know, I haven't flunked one yet.

Q: Do you take any medications?

A: I take—I had my physical and everything. Men are subject to prostate cancer and I am taking two tablets of [over-the-counter medication] and I take a Bayer aspirin every other day. And I have been buying these vitamins—Centrum that Paul Harvey—those are one-a-day. That's all I take. And I'm a big milk drinker. And Mimi is an excellent cook. She doesn't do a lot of grease and things.

Test #1: Policy A

Questions: A, B, and C

Question A: [Talked about a trip to Spain and how he wouldn't want to be taken care of in Italy or anywhere in Europe but Germany.] Let's see if it has anything to say about that. It says here you have the choice of any licensed physician, surgeon or any licensed hospital [Note: reads this from page 2.] You only have to presume that if that happens to you in England or Germany or Spain or wherever in Italy—they're not as competent in some of these places. My friends travel to Africa and different places and they have a special policy to fly them out of there. [Note: reads slowly down page 2 and then to page 3.] I think this is impressionable enough in a person's mind here, filing a claim and help lines that any question concerning any insurance needs call your agent and he will be of service to you. Then we get into the next page here. We get into *Agreement* and that is kind of short and sweet "we agree with you and we agree to pay". And then it goes to this reliance. [Note: reads page 3.] And I have run into one or two times...the last sentence that says that "benefits will change automatically to coincide with any changes in Medicare." I think they have to stay more atuned to that politically what is being passed and offered. We are just on the other end. We are the tail side and they are the head side. And we just have to say, oh, okay if you need another 100 bucks I guess we have to pay it. Differentiation, you know. We've noticed that every 2 to 3 years. And Medicare is the same way. [More talk about costs of insurance and politics.] Now do you want to go through definitions?

Q: I guess I would like you to see if there is anything in there about this question. Does it say that it does cover or doesn't cover? Or does it say anything at all about foreign coverage?



A: Okay lets look and see about overseas. Most of them exclude it so you have to pick up a rider. We went out of Kennedy and they asked us, "Do you have supplemental?" And Mark had covered me through his company. I don't see anything about overseas. [Note: turns pages slowly and reads headings.] Okay, Section C. Additional Benefits supplement—Medicare—emergency care in a foreign country. Will pay as follows. You pay the calendar year deductible of \$250 and we will pay 80% of the billed charges for Medicare eligible expenses. Which care began during the first 60 consecutive days of each trip outside the United States---which care began during the first 60 consecutive days of each trip. So you're covered the first 60 consecutive days subject to a lifetime maximum of \$50,000. So other than that, yes, they would cover it with those inclusions there. Then you get into the exclusions and limitations in there too. But you know the majority of people, and I'm guilty of this a lot of times to, lot of times just talk to the insurance man and he explains it and you really don't look at the fine print.

Question B: Well, now this...I'm assuming some things here. The way I'm going to answer this—this is supplemental. And Medicare is the major. So if I go in to see Dr. S. and of course he—McFarland Clinic and all of them file for us—to Medicare. Then they bill us and then we see how much Medicare allows and there is a difference. And then of course these are filed through the supplemental.

Q: So you would expect the doctor's office to take care of that?

A: Well, we would assume our carrier (which is the same one)...then they will tell us how much they will pay. And then there is a bottom line—you have \$74 hanging that we didn't approve.

Q: Say you were someone who just got this policy and didn't know what you had to do. I guess I would like you to take a look and pretend you don't know. Does it actually tell you this in this policy?

A: [Note: was on page 2 and noted heading.] Yes, that...this paragraph here now we're starting on "how do you file a claim." It's nice to give you kudos in the first sentence "We certainly hope you will not encounter a serious injury or illness...however. And it says the first step is "present your insurance card to the physician, hospital..." They have it down there.

Question C: About every year, I'm just guessing. Working with quite a few other insurance companies—there's no embarrassment. Once this policy, can they increase the premium charges? So I scan the sheet for that?

Q: Yes, if you had that question yourself, how would you normally look for the answer?

A: I look right up here—there's a red light already "Notice to Buyer: This policy may not cover all of your medical expenses." That flashes out at you [Note: reading from front page of policy. Then went to General Provisions on page 5 then turned back to page 4 and continuing to move backwards went to page 3.] Of course the

next page 4 *Exclusions and Limitations*, of course you always look at that. They always say with insurance, my grandfather taught me to say, the large print giveth and the small print taketh away. And it's true...And of course when you get into definition...you can't have all of this. You can't have all of this, what I'm really paying...this is hospitalization or this is accident. Or you get into skilled nursing facility. We obtained estimates and quotes through 5 or 6 firms and it pretty much leaves all of this out. And of course the benefits are large here and then it is small here. [Note: goes back to first page.] And that's under Medicare. And then the claims and general provisions and you get into the legal contract between you and ...and a lot of people do not seek advice from lawyers. And that's another flag. This is legal and I would rather go to my pro.

Q: Any idea where you might you would look to find the information about premiums?

A: [Note: goes to section on General Provisions again and finds the information] It could come from accidental injury or sickness. It looks like it would be expressly for-- this is supplemental. 30 Day right to examine. Renewability. This is closely related to...of course it is written off of national Medicare or Medicaid... All the guarantees subject to our rights...change rates subject to you remaining an Iowa resident. So you have to battle with them if you change states. Premium adjustment attained age rating. It says it may be changed—that's always a red flag. At our discretion is what they left out.

Q: So you say they can change?

A: They may. It's an ambiguous word. "In addition, your rates will increase yearly. Yes, it says there that we may change them. Premium adjustment/attained age rating. Your renewal premium may be changed if we change the premium for all policies of this form and class. And that's the clicker word. They say...now I'm turning 75 in June. So it doesn't meant...this all is not so definitive. My renewal premium may be changed at that time because I went into  $\frac{3}{4}$  of a centenarian so I'm in a new class. And the premium for all policies of this form and class in the state where you live. [Talked about different states.]

Q: So if you had that question, do you think that section pretty well answered it?

A: Well, that would answer it real well because here we talking premium adjustment/attained age rating. And you're not conscious of this all the way up 'til you get 70, well 65, or actually 62.

#### Post-test Interview: Policy A

Q: Any areas that caused you any trouble or any areas that were confusing or would be to someone else?

A: No, I think it's trying to be about three things. Of course one is it has to be written as a lawyer writes it. And it has to be written to protect...we're still under free enterprise...so it has to be written to meet their corporate policy requirements.

And of course it is taking care of the business and who is bringing the money...the subscribers to the plan. And they are the customers. There are really two more entities. We can leave out the cities and the counties pretty much but you have to consider the state and the federal. So once you have to figure that as an entity and of course the company is an entity, the provider, the policyholder.

Q: Given all of that this is pretty much how you would expect a policy to be written?

A: Yes, I think. I have gotten into in the past these exclusions and limitations and payment of claims. Of course they are in a different paragraph form. [Told a story about a law suit of a chemical company.]

Q: You don't think they could write it differently for policyholders?

A: Yes and on this is short and sweet, putting it easily. It's very well presented here. It brings out the...you see a real thick policy maybe 10 or x number larger than that and it gets really legally specific.

Q: You think someone without your experience would still be able to understand it?

A: It gives you the scope—the sphere, everything is inside but then you get into reading the fine print in the big thick policy.

Q: But as an overview?

A: Overview—and that's what it is. And I have had a situation where we did go through a specific policy—down in Davenport, a candy manufacturer and we made an analysis and we—actually this is what—[told a story about a client he had.]

Q: Looking at this, the way it is designed, the way it is written--do you have any suggestions for how to improve this document?

A: I think it's too—this is my opinion. If I were the prospective and you were the sales person, it's too condensed. It should be a little bit more comprehensive. It's kind of a quick...it is kind of like going shopping at WalMart and getting inside the door and making a fast run all the way around the four corners of the store and coming back out so you miss seeing...seeing specifics. What I am saying is that in my opinion you can draw these out all you want to but when you get into this and this and this. We have probably been guilty of buying insurance policies with something like this. I have learned...we lived in California 8 years, everybody is suing everybody. It's a different atmosphere and climate than Iowa. We started reading the fine print.

Q: So you think this one maybe doesn't give you enough information?

A: Well, if you want to be constructively...if you want to be...I can see where this is a nice, first evening you go through this and this and this...but probably the biggest problem, once you sign on the dotted line and they get your check and so forth...they never get back to you to give you the thick policy. And then when something happens you say, "Uh oh, why didn't you tell me there was an

exclusion there and that kind of thing." I am very close with my lawyer and a lot of it is preventative. So I've taken a policy in...and I have special policies just covering me...it was there...just covering me on their property....[talks about being covered when worked at other locations.] So I've sat down with lawyer and making sure how protected am I. Because you see there are these idiots...and you have to watch out on the L.A. freeway [told a story about driving on the L.A. freeway].

## Test #2: Policy B

Questions: D, E, and F

Question D: [Note: looks first at the TOC.] Okay it's A and B. [Note: moves to page 1 and begins reading.] Okay that's pretty clear. They offer supplemental benefits except for hospice. And B is pretty well...we offer you supplemental benefits in all these categories as stated in the benefits section, with the addition of benefits for medically necessary emergency care outside the United States.

Q: Anything about the deductible?

A: They probably get to that in deductibility here. [Note: continues scanning page by page.] I'm really dumb to that because I just sign things down at McFarland and what isn't covered then we give it to our carrier. And then we get the bill and she's done the books all these years. And I say here's something. We owe so and so for so and so and she takes care of that. I suppose it says we pay all of the Medicare A inpatient hospital deductible amount per benefit. This is A.

Q: What about part B?

A: I was looking at blood deductible because that's a big cost for a lot of people. They pay A and B for the cost of the first three pints. I don't see any deductible here. This one is for A here and it pays the deductible. Under Medicare blood deductible, we pay under Medicare parts A and B the reasonable costs and that's on blood and then we pay the coinsurance amount of Medicare eligible expenses under Part B and that's a deductible. This is deductible so I assume that's a deductible. [Note: turns to page 5.] That's coinsurance here. Then on Medicare A deductible. We pay all of the Medicare Part A hospital deductible amount for the benefit period. Yes, inpatient hospital deductible. It doesn't list the nursing facility who pays the deductible. And Medicare Part B deductible. We pay all of the Medicare part B deductible amount per calendar year regardless of hospital confinement. And here's 100% of excess charges.

Q: So they do cover it then?

A: Yes, and I can see if they do it in a foreign country... [Note: read this section.]

Question E: Okay, good question. We'll do this real fast and see if there is anything

here. It's not in a foreign country. And that probably jumps up many times with quite a few people. [Note: shuffles back and forth between pages scanning.] They pick up nursing facility days...they pick up for the charges from the 21<sup>st</sup> day through the 100th day. You have to pay that...from 1 to 20 somebody else has to pay that. They'll pay the 21<sup>st</sup> day to the 100<sup>th</sup> day. That does answer. That's nursing facility days and that is close to that....doctor decides skilled nursing care. Now it is approved by Medicare so the insurance company here is saying...oh, this is our insurance company.

Question F: I would say no. Consultation I don't think so but any work that he does...Millie could answer that better because she has had more. I just go in for physicals. Let's see this is related to the policy. Does it pay for doctor's office visits? [Note: looks at TOC and then starts scanning pages. Stopped on page 2.] This is out of state. They do by the way...back in Massachusetts, Mark has 48 acres and we spent 4 weeks there in July and August, and I had to go to the doctor because I got bitten by a deer tick and I got Lyme. Getting a hot fever and chills.....[tells long story about sickness.] [Note: continues scanning and reads headings.] Doctor's visits...they haven't specifically. That's a hospital [Note: looks at page 4 then to page 5.] Hospital...that's a hospital. That's a hospital. Hospital...hospital...hospital. [Note: reading from page 5 headings.] Out of country...It isn't in there at all that I have seen. Doctor's office visits...well, they should have that in here. Maybe I skipped over too fast. [Note: goes back over same pages. Looks on page 1 again and reads the text.] Doesn't mention it under A. I suppose it would be under B. Pays for physician services, outpatient hospital services, durable medical equipment. I suppose it is physician services. It doesn't specifically say a doctors' office. That's on page one. You'd have to blow that one up for the fine print in the policy. That's under Medicare part B.

Q: Does it say it will cover it?

A: It doesn't. Well it says physician services. [Told about episode of malaria.] But I don't see anything about doctor's visits. It's got out of state, out of country, nursing facility, Medicare. [Note: continues scanning pages.] It doesn't. We'll have to get on them.

#### Post-test Interview: Policy B

Q: Any part of the document that you think caused you trouble or any part that was confusing?

A: No, I think it's good for our kids age and even our grandsons. The print is a good sized print. And you can't help but be able to read the quality of the print. And they have it well organized here too.

Q: As far as the sections, the way it is divided?

A: Yea you've got the table of contents here and it pretty well it flows nicely with that. The benefits...the *Information* on 1, *Benefits* on 3 and *Services not covered*

on 7, *Your policy* on 9. If you want to skip the gobbeldy gook you go pretty much to 3 and services not covered and that's where I was going to peek now to see if that is where—if that approved office calls. It's got my curiosity. It doesn't say anything there either.

Q: Any suggestions for this policy—ways that it might be better?

A: No, I think...I don't think that our supplemental.... Our Medicare doesn't cover and I don't think our supplemental covers an office call and maybe they ought to put that in there.

Q: So they should be more specific about some of the information? That is kind of what you said about the other policy.

A: Yes, yes.

Q: How would you compare this one to the first one you looked at?

A: Well, this is a lot simpler to read as I say because of the larger print and it is not jammed in fine print on the same page—as far as readability is concerned think the first document was easier to understand.

Q: So you think spacing is better and size?

A: Yea, if I were an insurance person and I am going to go into somebody's home. He has a copy and they have a copy. You're going to lose a lot of people with that size print [policy A], our age. You come in there with something like this. I would rather have this tool here [policy B] than this.

Q: How about the way that it is divided up into sections, is one better than the other?

A: I think that laying it out like this—that's a good table of contents [policy B] so you can see where you're at. Now this one [policy A] possibly is too but you can see the difference. Now A could afford a few more pieces of paper to make that larger but....

Q: But as far as the information in the two, is the text better in one than the other?

A: This is readable, I mean I can read that very easy and everything, but if you are presenting it... I presume you're wanting to get the idea that you're presenting this to a customer. I am saying big is better.

Q: You do have a supplemental policy and it is this one?

A: Yes, I think it is that.

## Pre-Test Participant Questions.

Name: Dee Dee

Age: 89

March 22, 2001 at 10:00 a.m.

Q: What are your hobbies?

A: Needlework and crossword puzzles. And I read. I used to sew but I don't do that anymore.

Q: What kind of books do you like to read?

A: Oh, sometimes mysteries and romances, but I don't like these deep historical novels.

Q: Do you still travel? I know you drive.

A: I do drive, yes. I did travel when I was younger.... But I'm not doing that now.

Q: Do you play cards?

A: I can play cards but there's nobody here to play with. They have bingo here but I think well I just wouldn't bother.

Q: Are you able to do any kind of exercises with your arthritis?

A: They have exercises twice a week here but I don't go down—with my arthritis.

Q: Do you read the newspaper?

A: Yes, I take the Story City paper and the Nevada paper.

Q: How about TV, do you watch much TV?

A: I watch TV, sometimes the stories if I think they're good I watch them. But I watch the news and I paid attention to the election.

Q: Do you belong to any clubs or organizations?

A: I always belonged to the Ladies Aid over at the church but I don't go much any more. My church is in Roland—I belonged 70 years to it.

Q: Did you work outside the home?

A: Oh, yea. Do you remember Bourne? I worked there 10 years, and I run the machines. I worked—first they put me on the drill and then they put me on the screw machines where you loaded 15—I did that. And then those great big plastic molds. Then I had to quit and stay home with my husband. But you know, I went to get the job, I was about 50 years old. And he says we don't hire anybody that old and he says but if you can pass the test you're in. And do you know what we had to do? Little tiny things and I had to stick them in little holes with tweezers. And he says I guess you're in, you passed. Some of them you had to check with a micrometer and everything. [Chatted about her work at Bourne.]

- Q: So you had to quit that job to take care of your husband?  
A: Yes, but when I was first married, before I was married, I worked at Donnellys. And that's fine work too.
- Q: You said you had cataract surgery on both eyes? And your vision is 20/20?  
A: 20/20.
- Q: So you don't need large print?  
A: No, I've got trifocals. [
- Q: So you can read the newspaper print without any trouble?  
A: Yes.
- Q: You don't have glaucoma or macular degeneration or anything like that? You don't have any problem with your eyes?  
A: I can do some needlework but any fine stuff any more but I did that (points) and I did this (points to fine needlework framed on the wall).
- Q: Do you live alone? You're alone but not really alone? [Lives in a subsidized apartment building beside a nursing home. Everyone in the building is elderly and there are help buttons throughout. Meals are available through the nursing home if the resident desires. The building has a staff. She has a homemaker health aid come in once a week to help her bathe and to clean her apartment.]  
A: There's always someone and mail is down on the first floor and I go down and there's just all full of women waiting for the mail and they just sit there and visit. I have a daughter-in-law and a son in town and a sister in Ames and a daughter in Ames and I have a son in Chattfield, MN. I haven't seen him for a long time. When I go to Mayo clinic I stay with Virginia's daughter.
- Q: Tell me a little bit about your health. Arthritis, that's your biggest problem?  
A: Yes, today I've got a catch in my left shoulder so I put a hot—take a towel and put it in the microwave and put it over that shoulder. And the gal that was here from Homeward said you should put cold on it, don't ever put hot. Nuts to her. 30 seconds isn't too hot. She comes once a week. I said I don't think I need it that often but you have to.
- Q: Any other health problems, heart problems or breathing problems?  
A: No, I'm healthier than my kids. My son says, "Mom, you're going to outlive us all.
- Q: Do you take any medications?  
A: I take Meclazine just for my dizziness and just pain pills—Tylenol and sometimes a coated aspirin. I can't take the plain aspirin.



- Q: So the Meclazine you have an inner ear problem?  
 A: Oh, do I ever.... I went to Mayo and the eardrum is perforated and I have awful noises in the head. It wakes me up at night. [Tells more about her hearing problem. Wears a hearing aid.]
- Q: Do you have a supplemental insurance policy?  
 A: Yes, through P. I wouldn't dare drop it. All the things I've had done.
- Q: When you have something done do you ever look at your policy? Or do you depend on someone else.  
 A: Well, no sometimes if I don't understand I talk to Becky [her granddaughter]. She's pretty smart.
- Q: But you do look at it first yourself if you have a question.  
 A: No, what I do, when I go to the doctor, they send it both places.

Test #1: Policy A

Questions: D, E, and F

Question D: Well, I can tell you right now. The Medicare part A, they take it out of my check see—out of my social security check. So they pay for it.

- Q: But there's a deductible and that's what I'm asking about—the deductible. Some supplementals will pay that. I'd like you to look through this document and see if there is anything in there about the deductible.  
 A: [Note: starts by just reading the document from the beginning.] That's for the claims. I don't have to have a physical examination. Notice of claim—what does that mean? Oh, yeah, then you make out the claim form. Proof of loss—you have to have the proof that it is loss. But usually they file the claim and the doctor has it—they get it from the doctor. Time of payment of claim within 10 days—within 10 days I can get my part paid.
- Q: Does it refer to the deductible at all in there?  
 A: [Note: continues reading down the TOC.] No. *Deductible*. That's on the other side. *Consideration*—what's that? *Grace period*—you usually have 30 days grace. *Reinstatement*—well, you can do that too. *Suspension of coverage*—why would they do that? [I suppose if you don't pay.] I've never had that trouble. *Legal action*. *Misstatement of age*, well they've got proof of that. *Conformity with State Statutes*. Obey the laws? [Yes, and there's certain statutes that they have to follow.] Yes, they give you that. And *Periods of Insurance*. Well, like you—well, now your Medicare is for life after 65. And if you keep up you're the other one, part B, or your supplement, you keep that up yourself then you can renew it or let it lapse. *Membership Voting, annual meetings*. I never go to them. *Non-assessable policy*. What does that mean? [I have no idea what they are

talking about there. Continues reading down the TOC. This is the table of contents telling you where to look.] And definitions. What do you want to know about that?

Q: We want to find out about Medicare deductible, if there is anything in there about Medicare deductible.

A: [Note: starts reading headings on page 3.] *Agreement. Definitions.* [Starts reading subheadings under Definitions.] *Medicare. Calendar Year Deductible. Benefits to supplement Medicare. Benefit Period.* A benefit period starts with the first full day you are in a hospital. It ends when you have not been in a hospital or skilled nursing facility for at least 60 consecutive days.

Q: Anything about the deductible?

A: No, Medicare means the health insurance for the aged act. [Note: continues reading the definitions.] *Calendar year deductible.* This is the amount of Medicare eligible expenses you must pay each calendar year before benefits can be paid under Part B of Medicare. Oh, I see, you...they deduct that from you social security pay. And after that you can't be paid under part B unless that is paid.

Q: Unless the deductible is paid? Does this policy pay the deductible or you? Who pays the deductible, do you have to or does the policy? You don't think they cover it?

A: I have to. They send the bill, the statement, and the amount, but then I have to pay that. But then when it comes to be \$100 they notify that you have now paid the deductible.

Q: So here they are telling you what—about what the deductible is.

A: It's the amount of Medicare eligible expenses you must pay. Well you have to pay until you get to the deductible.

Q: So your understanding is that you pay it, they don't pay it?

A: No, they don't pay it. It says you need to meet this deductible only once in a calendar year. When it first starts.

Question E: It seems to me on the policy that they will pay 120 days. That would be supplement.

Q: Why don't you look in there...somebody that doesn't know that, how would they find out? It's for skilled nursing care.

A: Skilled Nursing Facility. [Note: scans down to the bottom of page 3 that she was already on.] We will pay the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup>. So they do pay it.

Q: So Medicare would pay the first 20 and they would pay 21 through 100. So 100 through 120, who would pay that? You would pay that? So if you had to be in 120 days, you would be stuck with the last 20 days?

A: Yes, probably.

Q: Do you think that was pretty clear?

A: Yes, we will pay the actual billed charges up to the coinsurance...and then your coinsurance takes over...amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a benefit period for post-hospital skilled nursing care.

Question F: Yes.

Q: You just know everything already. Pretend you don't know what it does and you are trying to figure it out. See if it tells you in there.

A: I go to the doctor and he will send the charge to Medicare. And then I get a check...not a check I get a statement from Medicare that they allow so much off of that doctor bill. And my policy pays what's left. But my doctor increased his office call, but anything over that I have to pay. Because the supplement pays 20% of what Medicare pays, and anything over that I have to pay.

Q: Let's pretend you didn't know that and you had this policy and you had to go to the doctor and you wanted to figure out whether or not this would cover it. I want you to look through wherever you need to look in there and see if it actually says in here that it covers it. If it does cover it, it should tell you, right?

A: Would that be in here or where? *Exclusions and limitations*, would it be in there? It says *Emergency care in a foreign country*...why that doesn't amount to... Part B...says Medicare pays for part B services and supplies. They don't pay on B. They pay part A.

Q: Some people get part B also.

A: No, I get part A and the supplement takes the B. Yes, so I don't have that.

Q: What's your understanding that part B is?

A: Well, part B is what Medicare doesn't pay, so that is why the supplement pays part B.

Q: So do they pay doctor's office visits, do you think, whatever Medicare doesn't pay?

A: Medicare pays for 20% of your Medicare eligible expenses. [Note: reading from page 3.] They pay 20% of the incurred for those Medicare part B services and supplies and 100% of the difference between the actual billed amount for those who have had the Part B. But I haven't had that. So they pay 80% and supplement pays 20%. Just straight over the board.

Q: [So this one pays what?

A: 20% of your Medicare eligible expenses.

Q: That would be doctor's office, do you think?

A: Doesn't say doctor's office. If you are charged a non-replacement fee for a blood transfusion, we will pay this fee for the first three pints of blood. Well, not me, I use my own blood. If you are not enrolled in part B of Medicare, we will pay benefits as if you were enrolled.

Q: Which means they pay part B? But is part B the doctor's office?

A: Part B is for the doctors office and for anything else. I know when I had my knee done, Medicare paid 80% and the supplement paid the rest. So I never had to pay a penny for it.

#### Post-test Interview: Policy A

Q: Is there any place in this document that causes you trouble? Anyplace when we were trying to find the answers that you thought was troubling or confusing?

A: No, no trouble.

Q: What did you think of the table of contents?

A: Well, claims it says here, notice of claims, claim forms. Well, I know all that. I know proof of loss. I know all that.

Q: But for someone that didn't, do you think it is set up in a way that would be helpful, or do you think they could do it differently?

A: No, the way they've got it set up, it just works.

Q: What part, if any, of the document seemed confusing? What about the way this is written? When you were reading here, when you were reading the part on page 3, was it written in a way that made sense? Like when you were reading the definitions, were these helpful? Especially for someone who doesn't know as much as you do?

A: Let's see Medicare eligible expenses...expenses of the kinds covered by Medicare, to the extent recognized as reasonable and customary and medically necessary by Medicare. Any expense of portion of expense that Medicare considers unreasonable, unnecessary or in excess of the Medicare legal limiting charge is not a Medicare eligible expense. That's what you have to pay.

Q: So, it makes sense?

A: It does to me. Yes, because anything that Medicare or supplement don't pay, you pay. The doctor has raised his office call to \$41. It used to be right on Medicare, which is 26 or something. Now Medicare will only pay the 26 and I have to pay the rest. The supplement will pay 20% of what Medicare pays and that is all.

Q: What parts of the document were particularly helpful? What do you think about the headings, the type, just the look of the document? Just the way they do the document. I'm talking about how the document is designed.

A: Well, anybody with any sense could understand it. I think so.

Q: So you think that overall it's a pretty good document?

A: Hospital confinement benefits. When Medicare pays for your stay in a hospital we will pay your initial deductible for the benefit period. That's A. Beginning with the 61<sup>st</sup> day and continuing through the 90<sup>th</sup> day of confinement, all of the other Medicare eligible expenses under Medicare part A is not paid, but your supplement will pay that. And this nursing insurance...you have anything in here about that...long term care. That's for the birds. I signed up once for it. My doctor said you don't need that, so I cancelled it. [Tells story about long term care policy.]

Q: Do you have any suggestions for how to improve this document?

A: I can understand it.

#### Test #2: Policy B

Questions: A, B, and C

Question A: [Note: does not look at the TOC. Scanned through looking at headings.]

Medically necessary emergency care in a foreign country. Is that it? To the extent not covered by Medicare we pay for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000—that is for an accident and everything. The emergency care must have been eligible for coverage by Medicare if provided in the United States, and the care must have begun during the first 60 consecutive days of each trip outside the United States. For purposes of this benefit, emergency care needed immediately because of an injury. Well, anybody would know that. They would. It is very clear.

Q: So this makes it clear what they pay? It is spelled out fairly clearly?

A: Sure, they go by what they pay here in this country.

Question B: Where would that be? [Note: looks at headings.] Filing claims. You do not need to file a claim with Medicare for any services. By law, physicians or other suppliers must fill out claim forms for you and send them to Medicare even if they do not accept assignment. And they also send it to the supplement. I don't know if all of them do, but mine does anyway. You should always make sure your providers know that you have supplemental coverage with us. When you receive health services in your home state, Medicare will automatically send your claim to us.

Q: So that's pretty clear?

A: Yes, it's pretty clear.

Question C: Well, they haven't for Medicare.

Q: How about the supplement? Do they say anything in this document about the premiums?

A: No, they just say 20% of what Medicare pays.

Q: No, I'm talking about what you pay for your supplement. You pay once a month or every three months?

A: I did pay every 3 months but I had to change to every month because my income went down.

Q: That part that you pay have they every increase that?

A: Not that I remember.

Q: I want you to take a look and see if they say anything in there about it—about the premium and what they charge. Let me know what you're thinking as you look and are reading.

A: [Told a story about having her toenails trimmed and how it was and wasn't covered.]

Q: Let's look in here and see if they say anything about what they can charge for this policy. Can they ever raise their rates and when?

A: [Note: scans pages and looks at headings.] It doesn't say anything about the premiums. If you fail to pay any monthly renewal premium within the 31-day grace period—they always have a grace period. You may request reinstatement of this policy by submitting an application for reinstatement. Well that's clear. I never had to do that because I always paid it ahead of time. No agent, employee or representative of ours is authorized to vary, add to, change, modify, waive or alter any of the provision of this policy. This policy cannot be changed except by written amendment signed by one of our authorized officers and accepted by you as shown by payment of the monthly premium. It was clear.

Q: Nothing about whether they can raise the premiums or change them?

A: *When coverage begins. Premiums.* You must pay us in advance. *A grace period.* No, it doesn't say anything. Increases benefits with an increase in premium during the policy term unless the increase in benefits is required by law. Premium changes. You have the right to change your premium upon our implementation of new table of rates, an increase in your age, or a change in Medicare's benefits. If we do change your premium, we will notify you at least 30 days before the change.

- Q: So they pretty well spell it out there when they can change it?  
 A: You have the right to change your premium upon our implementation of a new table of rates, an increase in your age.
- Q: So they can change the premium as you get older, is that what they're saying?  
 A: I think so. I never had it changed. Never bothered with it. I didn't want to monkey with it. I thought maybe they would do something I didn't like. You never know and you don't dare drop it.

Post-Test Interview: Policy B

- Q: Any place in this document that you had trouble?  
 A: I don't know much about this. I don't have that.
- Q: Did you find any parts that were confusing?  
 A: No, it's clear.
- Q: What parts of the document were particularly helpful? I noticed that you looked at the headings, were they pretty well done?  
 A: Yes. When you look at the headings, that's how you see what you want to read.
- Q: Any way that this document could be done better?  
 A: It's okay this way.
- Q: How would you compare these documents? Is one of them better than the other?  
 A: I can understand both of them.
- Q: One isn't any easier?  
 A: No.
- Q: The wording is clear in both?  
 A: I could understand the words, I don't know if other people can.

Pre-Test Participant Questions

Name: Pansy

Age: 69 y/o

March 22, 2001 at 1:00 p.m.

Q: You said you like to read, any special kinds of books?

A: Yes. I read a little bit of everything.

Q: Do you travel?

A: We did but my husband has heart problems so we haven't been anywhere for the last year.

Q: Probably with your breathing problems you're not able to exercise.

A: Right.

Q: And no volunteer work or anything like that?

A: No. It just limits me. It really does.

Q: Do you read the newspaper daily or watch TV regularly?

A: Oh, yes, we take both the morning and the evening papers. I read them both. I watch the news on TV of course.

Q: Keep up on what's going on?

A: Right. Sometimes I'd rather not.

Q: Are you a member of and active in any clubs or organizations or do you serve on any committees (such as church committees)?

A: No, not now I'm not.

Q: I assume you are not working? Did you work outside the home?

A: No, no.

Q: Any problems with your vision?

A: No.

Q: No cataracts? You don't need large print? No glaucoma or macular degeneration?

A: No. No. I just need glasses is all.

Q: Do you have family close by? [Lives with husband who has significant heart problems.]

A: I have a daughter in California and I have a daughter here in Ames. She lives on 20<sup>th</sup> street, so close by. I lived in Nevada. We just moved here last April. [Talked about Dee Dee, who used to be her neighbor.]



Q: Just a little bit about your health—do you have emphysema, is that your breathing problem?

A: Yea.

Q: Any other chronic health problems of any kind?

A: No, I'm healthy otherwise but see that breathing makes it really limited.

Q: Do you take breathing treatments?

A: No, I have a nebulizer that I use and I also have inhalers. Everything's fine except that.

Test #1: Policy B

Questions: A, B, and C

Question A: Do you want me to read this part here? [Note: talking about front cover of the policy.] [Do whatever you would normally do.] Well, normally I'd go to the policy I'm sure. Start towards the back I think. My hands are so dry I have a hard time turning the paper.

Q: Do you tend to look at the headings as you go down?

A: Yea, yes. Well, on the front of it it said something about the coverage for foreign countries.

Q: It said it on the table of contents?

A: Yea, but I don't see which page. I hope there isn't a time period on this. [No, no, not at all.] Medically necessary emergency care in a foreign country, but it doesn't say what page. [Note: was looking at the index.] I've certainly used a lot of it. My husband has been sick for so long. I guess I'll have to start through it and see. [Note: slowly skims pages.] We've certainly used a lot of it, I'll tell you that because my husband has been sick for so long. [Note: continues scanning pages.]

Q: Is it pretty much the headings you are checking as you look down the pages?

A: Yes, right. Well, it is telling me that they pay 80% of what Medicare does not approve...or not cover, I should say. It has to be eligible to be covered by Medicare and then they pay 80%.

Q: So it is covered by this policy?

A: Yes.

Question B: Well, they do it for us at the doctor's office, but I don't know.

Q: Do they allow you to do that in this policy?

A: [Note: scans through pages—did not look at the TOC.] You don't need to do that it says that by law the physicians and other suppliers have to do it. And make sure your provider knows the supplemental insurance that you have.

Question C: I happen to know that. As you get older they change it. But I'll look it up and see. Can they increase? I'm not finding it. Well, it's got to be in here because I know they do. [Note: just scans through looking at headings.] Yes, it's right here. It says they have the right to change premium upon implementation of a new table of rates, an increase in your age, or a change in Medicare's benefits. And if they do they have to notify you at least 30 days.

Post-test Interview: Policy B

Q: Was there any place in this document that caused you trouble?

A: Frankly not, because I already know what it does.

Q: It's hard to look at it objectively?

A: Yes, it is.

Q: As you scanned through, you looked at the headings, were they pretty well done?

A: The headlines, yes.

Q: Do you think those are pretty important?

A: I think they are, yes, because they tell you what you are looking for.

Q: Do you think these are labeled pretty well?

A: Yes, I do. They tell you what you are looking for.

Q: Anything about this document, the way it is designed or written or the wording that could be better?

A: It seemed to me like it is pretty self-explanatory. Pretty easy to understand the way it is written. Okay this way.

Q: Do you have a Medicare Supplemental Policy?

A: Yes.

Q: Do you ever refer to it when you have a medical claim?

A: Yes, Blue Cross. Yes, because they explained it to us when we first got it and I guess if we ever had any problems I would.

Test #2: Policy A

Questions: D, E, and F

Question D: According to this?

Q: If you can, read out loud what you are looking at.

A: I suppose. I know that's what you want. I'm not use to this policy—this company at all [Note: scanning and turning the pages.]

Q: It's a different style.

A: Yes, completely. I'm supposed to find out who pays the deductible. Okay. It says here that the amount of the Medicare eligible expenses you must pay each calendar year before benefits can be paid under Medicare. You need to meet this deductible only once in a calendar year. That's part B.

Q: So they're saying that you have to pay it?

A: Un huh.

Q: How about part A?

A: Well, it should be. Maybe it is down here. [Note: looking at section A.] It says when Medicare pays for your stay in the hospital they will pay for your initial deductible for the benefit period. Is that what I'm looking for?

Q: So they will pay it?

A: Yes, if you're in the hospital, That is A. Yes, they will pay for your initial deductible benefit period—if you're in the hospital. I don't find anything else that says.... [Note: seems frustrated.] I don't know, I can't find anything else.

Question E: It says here that no benefits are provided for the daily co-payment amount under Medicare Part A for skilled nursing care above the number of days covered by Medicare. [Note: remained on the same page from the last question and read that from *Exclusions and Limitations*.]

Q: So you have to know for sure what Medicare covers?

A: Right, right. [Note: rereading the same section.] I think that's it.

Q: So whatever Medicare covers, it will pay?

A: It'll pay.

Q: It doesn't indicate how much Medicare would cover?

A: No.

Question F: I'm not sure, is it Medicare B that is the doctor? I think it is. I'm not really sure of that, isn't that terrible. [Note: scanning pages very briefly from page 4 on.] No, [inaudible]. I hope you're not in a hurry. It seems like it takes me a lot of time.

Q: No, not at all. You're doing great. [Note: starts at the beginning of the document, then reads the *Exclusions* section and then the *Additional Benefits* then general provisions.]

A: I'm looking at *Exclusions and Limitations*. But you'd think that they would have a place somewhere that would tell you whether they pay for the doctor. [Note: looks now only in *Exclusions and Limitations*.] Well, I suppose they don't pay for it. I got through that.

Q: They don't say anything about it?

A: No. I'm not finding it but surely.... [Note: continues to read same two sections very carefully,] I'm sure that it's in here somewhere but I don't find it.

Q: It's not obvious that it is in there?

A: I can't find it.

#### Post-test Interview: Policy A

Q: Any parts of this document that caused you trouble?

A: Well, I don't like the way it is put together, no.

Q: Like the way it is written?

A: Yes, they should have it—I don't know, I think they should have it so you know where to look for stuff. Well, I guess they do in a way. But I can't find this. It says *Benefits under part B of Medicare* and I don't know where that's at. Page 3 it says. And I don't see it. And I don't see anything about the doctor.

Q: What do you think about print design, the way it is sectioned off? Is that better or worse than the other one? The headings? You used the headings a lot in the other one.

A: I liked the other one better. Yes, they were, they were much clearer for me.

Q: They use a lot of bolding in this one. Is that good or bad?

A: Well, it probably helps don't you think.

Q: Were you drawn to that?

A: Yes, I was. I just can't believe I can't find it the eligible. [Note: seems embarrassed.] I'm sure it has to be in there but I can't find it.

Q: What parts of the document, about the design, were particularly helpful? You mentioned that it had an index.

A: It just doesn't seem to be—I think the other one was better

Q: So when you compare those, on the other one the headings were better and you thought the index was better?

A: Right, and it is easier to read too.

Q: The size and the way it is spaced?

A: Yes.

Q: Do you think it is worded more understandable or do you think that is about the same?

A: Well, I think about the same.

Q: When you found what you needed to read in this second document...

A: It was easy to read, yes.

Q: So it is more really the design of it?

A: Yes. I just can't believe I couldn't find that. I still say you know it has to be in there somewhere. The other one was much easier.

## Pre-Test Participant Questions

Name: Punjab

Age: 79 y/o

March 27, 2001 at 2:00 p.m.

Q: What are your hobbies? What kind of things do you like to do?

A: Play 18 holes of golf 5 to 7 days a week, weather permitting. Although we've been known to wear heavy mittens.

Q: Do you like to travel?

A: Yes, quite a bit. Neither one of us like to drive any more so we do a lot of buses. We just got back from a 19 day one. We went to Phoenix. It was a fun thing to do. There were only 25 of us on this bus and a 44 seat and you can spread out and do whatever you want and read. I got a little thing called a GPS unit. It's about this size and its got all kinds of little buttons. You pick up satellites and it tells you your direction you're going, how fast you're going, your latitude and longitude. It makes a map. I had that on an airplane. I measured that son of a gun at 630 mph all the way from Denver—well almost all of the way—to Des Moines. [Told the rest of this story about his GPS unit.]

Q: Any other hobbies? You like to read? Play cards?

A: We play cards. We play bridge. And I play cribbage through the summer months with the golfers.

Q: How about exercise? Obviously you walk with golf.

A: We do the walking, yes. And then we have a treadmill and a stationary bicycle. Don't ride as much as we should but we use them. And, of course, I have that dang computer that I like real well. Spend extra time with that.

Q: Do you read the newspaper daily or watch TV regularly?

A: Yes, I read the paper. Not as much TV as I used to. I like the history channel really well. Not all of it is good, but most of it is. I don't know how we got hooked into it, but we watched a movie last night, that was just—we we thought it would be a great movie like when we first saw it—South Pacific. It stunk!! It was strictly a class B movie.

Q: How about clubs, organizations—are you an active a member of any?

A: Well, I'm still a member of my state association—Iowa Optometric Association, the National Optometric Association—Iowa AOA. Rotary, real active in Rotary—Monday noon. But Rotary is a great organization. They have done a lot of good things. Eradicating the world of polio almost now is one of the big things—well we didn't do it but funded it.

- Q: Well, you're retired, but obviously you stay connected to your field?  
A: Well, I don't go down to the office any more but I still get all kinds of mailings.
- Q: At least keep somewhat abreast of what is going on in that area?  
A: Oh, yes.
- Q: How about your vision? How is your vision? Have you had any problems with your vision?  
A: We've had cataract surgery—both of us. Jim Davis over in Marshalltown did it. I've know Jim a long time. Don't ever play golf with him. [Talked about golf a while.]
- Q: So your vision is fine? You don't have any problems with macular degeneration or glaucoma?  
A: Oh, no, I've had no problems with MD at all. 20/20 right and left both near and far.
- Q: Do you live alone? Do you have family close by? Do you still drive?  
[Lives with wife. Still drives.]
- Q: I would gather from looking at you that you are in good health. Do you have any health problems?  
A: They started me on a pill not too long ago—Lipitor—for cholesterol. I feel good I really do. I'm getting over a little cold right now. My voice is still a little scratchy.

Test #1: Policy B

Questions: D, E, and F

Question D: Well, this one does.

- Q: Let's pretend you don't know that. How would you find that out in this document?  
A: Oh, all right. [Note: looks at TOC.] Services covered, I suppose. Medicate Part A. Part B, that's hospitalization, isn't it, and A is coinsurance or something like that. I have no idea how to find it. I've never looked at one of these things before. We've done this so much and (my wife) usually does it all. I don't pay much attention to it really. We just came from the dermatologist and that will be covered I suppose. We still owe the clinic for an exam that I had three months ago, but I'll pay it eventually I suppose. [Talked about treatment by the dermatologist.] I don't know what I am supposed to tell you.

Q: There is a deductible for Medicare part A and part B. Do they cover it? Do you have to pay it? Say you were someone who lives alone and have this policy and wanted to figure out what is covered.

A: [Note: scans pages from 3 to 5] Well, Medicare Part A. We pay all of Medicare Part A inpatient hospital... and then down here Medicare part B...we pay all of the Medicare Part B deductible, etc., etc. Is that what you wanted to know?

Question E: We have nursing home insurance.

Q: Skilled care is different from nursing home care. It might take place in a nursing home and sometimes it is in a hospital. It's just a step down from regular full hospital care.

A: You've really got me cornered because I don't anything about this stuff and I don't really care about it. [Note: seems embarrassed and frustrated that he doesn't know this.] Emergency, is that what we're talking about?

Q: No, we're actually talking about skilled nursing care.

A: [Note: looks at the *Benefits* section] Foreign countries, 61 through 90, 91 through 120. First what days? Hospital...I don't know. I'm embarrassed because I don't know. Well, I think it would probably be handled all right, I am not worried about that. Who pays for it? I can pay for it as far as that goes. [Note: frustrated and embarrassed.]

Q: Are you saying you want to go on to the next one?

A: Yes. Yes.

Question F: Not really, unless I have a malady that is covered by that. I don't think so. Physical examinations and those kinds of thing it doesn't cover it.

Q: Does it say that in there?

A: You mean look for it? No. If I had this thing before and could look through it then I could help you with this. But it's brand new. I don't recall ever having seen this before. I suppose we have one of them someplace.

Q: What I am trying to figure out is if this information is accessible in these documents. Is it written so people can understand it?

A: Oh, I think so. I just have never read it.

Post-test Interview: Policy B

Q: As you were looking through it, it looked to me like you were using the headings, is that the way you would normally go through it?

A: I think so, yes.



Q: Did any parts give you trouble? What do you think about the way it is designed, the way it is written?

A: Now look, Medicare Part B Coinsurance...Medicare Part B Deductible. Why aren't these put together? Why aren't they loaded up with each other instead of interspersing here. That doesn't make sense to me at all.

Q: What about—you looked at the table of contents. What did you think of that?

A: Over here? Part A and part—se part A is surgery, etc., doctor's and physician's care. Part B is hospitalization and all that kind of stuff. Is that right?

Q: Does this look like a useable table of contents to you?

A: I suppose. Whatever.

Q: [Asked earlier] Do you have a Medicare Supplemental Policy?

A: I suppose we have one of these someplace.

Test #2: Policy A

Questions: A, B, and C.

Question A: [Note: starts by looking at TOC then scans the front page.] Yes, your renewal premium may be changed if we change the premium for all policies of this form. Not just for me—for everybody.

Q: So it is pretty well spelled out?

A: Yes

Question B: [Note: turns to next page—a little frustrated with test.] How to file a claim. I'll look for it first. How to file a claim. Yes, insurance card.

Q: It's pretty well spelled out then?

A: Yes.

Question C: [Note: looks at TOC again.] I don't see here where it says here while you're not in the U.S. of A. [Note: scans several pages.] I suppose I would find it eventually. If I'm out of the country and get sick for 30 days does this cover it?

Q: Yes, if you had to have emergency surgery.

A: Hospitalization and so on? This is an IQ test, you know that. My reading 5 IQ is just firing away (laughs) as fast as it will go. [Note: scans page 4.] 80% of billed charges for Medicare...hospital, physician and medical received in a foreign country which care would have been covered by Medicare if provided in the United States and. That what you want then?

Post-test Interview: Policy A

Q: What did you think about the way this document is designed?

A: Oh, they are all right. They are all stupid. It's kind of like when a guy wants an answer to something, why isn't that answer right here, you know, instead of having to fuss through a whole bunch of other answers to find out.

Q: Any comparisons between the first one and this one? They are designed quite differently and the wording is quite different too.

A: I think this is simpler to read (policy B) for most people than this (policy A). Having been an optometrist I would know about this, very often a person will lose his place. Let's see now which line was I on and trying to find it over here, following everything with his finger. While over here (policy B) it's a lot simpler to follow.

Q: Do you have a Medicare Supplemental Policy? Do you ever refer to it when you have a medical claim?

A: It's W.

Q: And the doctors know that you have it and they take care of filing and everything?

A: Sure. Sure.

**Pre-Test Participant Questions**

**Name:** Louise

**Age:** 79 y/o

**March 28, 2001 at 2:30 p.m.**

**Q:** What are your hobbies? Are you a golfer too?

**A:** No, I'm not a golfer.

**Q:** What kinds of things do you like to do?

**A:** Well, I was a color consultant, but mostly I've been a secretary and then I helped Punjab in his office until he retired. And then my mother died in September and was 102 and she's been in a nursing home and in her own apartment for 10 years and that's kind of been my hobby. So now I am just kind of looking. I do a lot of Christian work—Bible study and things like that.

**Q:** And he mentioned that you travel.

**A:** Oh, sure, we travel, and we'll be able to do more now and it's too bad that's like 10 years out of our life, but that's what the Lord had for us so that's fine.

**Q:** And that you play bridge?

**A:** Oh, yeah, I play bridge.

**Q:** Do you like to read?

**A:** Oh, sure, and I like politics. I watch political stations.

**Q:** Exercise? He mentioned that you have a treadmill.

**A:** We have a treadmill but we don't use it as much as we should.

**Q:** Do you do any volunteer work?

**A:** At the hospital we do the art cart. I'm going to do more of that now. We've been doing that for probably 15 years.

**Q:** Do you read the newspaper?

**A:** Politics (laughs), yes.

**Q:** Watch TV?

**A:** Yes, again I watch more political things. I watch Fox newscast, investment things and stuff like that.

**Q:** Are you a member of and active in any clubs or organizations or do you serve on any committees (such as church committees)?

**A:** We're both Evangelical Free and I would say we are active.

Q: Your vision, do you have any problems with your vision?

A: I have an epiretinal membrane, glaucoma, and I've had cataract surgery. I have the retinal problem in this eye [left]. I have some floaters, but maybe getting more. I've had tremendous vision and then had to start this. I could read for a long time without my glasses on. I had great contacts I don't know, anything like this is scary.

Q: You don't require large print to read?

A: No.

Q: How would you describe your general health? Any problems?

A: Mostly, I'm healthy. They just told me---I cough so much and through all of mother's stuff I really didn't---it came on gradually. My sister wouldn't go home until I was tested. And so now they say---I was tested. So I have old-age allergies and it could be from all the drops I'm using. And I have a reflux problem which is normal. Like we went to the skin doctor this morning. And he was...I was asking him about all these brown spots I have. He never once said, "At your age." And I said, "That's really nice, you've never said it is my age related." And he said, "You know, that's my wisdom."

Test #1: Policy A

Questions: D, E, and F

Question D: It should be up here in the... [Note: looks at top of first page]. [Gave the name of the company.]

Q: That's the company and what we want to know is, as you look through the document, do they pay the deductible or do you have to pay it?

A: Oh, who pays the deductible? There is a benefit period. A calendar year deductible amount. They have reserve days. [Note: reading down the TOC.] Who pays it? [Note: continues to read TOC.] Benefits under part A of Medicare, Benefits under part B. "We agree to pay you benefits for Medicare eligible expenses. [Note: reads from bottom of page 1.]

Q: So you assume that that is deductible part?

A: Yes.

Question E: [Note: looks at page 1 again.] Do you want me to go on from here?

Q: Yes, just scan through it or however you might go through.

A: Oh, here's where they are. [Note: moves through page 2 to page 3.] It starts... [looking on page 3 at definitions] Hmm, calendar year deductible---what is? 60 additional days? But this is supposed to be in skilled care. Skilled Nursing Facility means....well, I know that. [Note: looks down to the bottom of the page.]

Oh, we will pay the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day—after ten days. They pay the 100 and probably you are required to pay the last 20.

Question F: Let's see. It's in here I assume. [Note: looks under *Exclusions and Limitations*.] Doctors. [Note: goes to *Payment of Claims* section] It says "we, at our own expense, have the right to have you examined as often as reasonably necessary while claim is pending. Payment of claims—benefits will be paid to you unless they have been assigned to a doctor...Any benefits unpaid..."—I'm in the wrong place, I think. [Note: scans to last page and then back to page 4.] I don't think it pays. I'm just not in the right place. I'm not good at reading these things. [Note: continues reading from text in sections on page 4.] Additional benefits to supplement—foreign care. Huh. Routine for physical examinations, it does not. Or glasses. [Note: looking in exclusions again.] I don't—I don't see it. But I know that most policies do pay for some part of the doctor's visit. I'm having trouble. That should be up here probably. [Note: looked at *General Provisions*] Let's give up on that.

#### Post-test Interview: Policy A

Q: Is there anything in the way of design that makes this document difficult as you go through it?

A: No, it's just a normal plan.

Q: Any particular thing in the design or the way it is written that is particularly helpful? They use a lot of bolding in here and headings, are they helpful?

A: I think they're helpful. They stand out. I mean you look at those. Yes, you first look at those. Oh, you have a choice...yea, well, they must pay for a physician if you have a choice.

Q: So there are lots of indications that they pay for physicians?

A: Yes.

#### Test #2: Policy B

Questions: A, B, and C

Question A: [Note: looks at the TOC.] Well, it's supposed to be on page 3. [Note: looks at page 3, scans down the page, and then back to the TOC.] Hmm. *Medically Necessary Emergency Care in a Foreign Country*. 1, 2, 3. [Note: continues to look on page 3.] Well...well, unless I'm missing it, I don't see where it says a foreign country. Well, it's got to be somewhere else, because they have to have that. Humph, it's on page 5. To the extent not covered by Medicare....yes, suppose you are traveling and become sick and require...is it covered? There's a

deductible and a benefit of \$50,000. Eligible for coverage. Yes. Doesn't say anything here about... [Note: goes back to TOC.] Must be 3 to 7.

Question B: [Note: has document open to page 6 from last question and then went to page 7.] I think you would call their toll free number and ask.

Q: They give you that in there?

A: Well, it just says "if you have any questions after reading your Medicare handbook please call us or seek for help for service nearest you." So I suppose it's the doctor too. Generally, we go to the doctor and then we ask, right? It goes into...this is how it starts. Well, I would say, yes, you would call.

Question C: [Note: ends last question on page 9 so looks there first for this question.] They will renew it each month? Each calendar month. A grace period. And if you fail to pay.... Increases benefits with an increase in premium. This cannot be changed except by written amendment. You would have to have a written amendment I guess. We have a right to change our premium. I think they...have to have a written amendment.

Post-test Interview: Policy B

Q: Where in this document did you feel you were having trouble?

A: I like this one better. The way it is laid out. This one [policy A] is more like real policies.

Q: Do you think this one [policy B] is easier to use?

A: Yes, I do.

Q: What parts of the document were particularly helpful? What do you think about the headings, the type, just the look of the document? Just the way they do the document. I'm talking about how the document is designed.

A: Well, they give you an index sort of—the table of contents was good.

Q: Do you have any suggestions for how to improve this document?

A: Not in this length of time, you can't tell that. I can't.

Q: Do you have a Medicare Supplemental Policy?

A: We have W., the supplement. We have long-term care.

Q: Do you ever refer to it when you have a medical claim?

A: No. You just go ask questions.

**Pre-Test Participant Questions**

**Name:** Flossie

**Age:** 74 y/o

**March 28, 2001 at 1:00 p.m.**

**Q:** What are your hobbies? What kinds of things do you like to do?

**A:** I like to read. Novels—various kinds. My daughters [inaudible about daughter's recommendations for various kinds of novels and about the one she is reading now.] I also like to travel. I substitute bridge once in a while but I'm not really into cards.. I do exercise. I just completed cardiac rehab. And I am supposed to be continuing. I had triple bypass. Oh, yes, I'm keeping up. [Do you do any volunteer work?] I only volunteer with my daughter-in-law. She has lupus and so whenever I have time to spend I help her out. I hope to be doing more with church soon. We're moving into a new building edition.

**Q:** Do you read the newspaper daily or watch TV regularly?

**A:** Yes, but I watch very little TV.

**Q:** Are you a member of and active in any clubs or organizations or do you serve on any committees (such as church committees)?

**A:** PEO.

**Q:** Do you stay connected to nursing in any way? [We talked before the interview started. She is a retired nurse. Started the local visiting nurse service many years ago. Retired 12 years ago.]

**A:** No

**Q:** Do you have any problems with your vision?

**A:** No, I have beginning cataracts.

**Q:** Do you have macular degeneration or glaucoma?

**A:** No, no other problems.

**Q:** You don't need large print for reading?

**A:** No

**Q:** Do you have family close by? [Lives with husband in own home.]

**A:** Two daughters here in town and a son in Marshalltown.

**Q:** Do you still drive?

**A:** Yes

- Q: How would you describe your general health? You had a triple bypass.  
A: Bypass surgery in November. I have fibromyalgia also. Outside of that, I consider myself pretty healthy. I have asthma, but my asthma only affects me if I have a cold.

Test #1: Policy B

Questions: A, B, and C

Question A: Well, I think I'll start at the back because I think it may be there. It may be closer to the back if it is in there. I'm not very likely to be traveling in Italy. Especially since my heart problems. [Note: starts at back of document and scans as moves forward. Read inaudibly from the correct passage.] ...up to a maximum cost of \$50,000.

- Q: So it's pretty clear?  
A: Yes, very clear.

Question B: [Note: continues to scan and move forward in the document.] It says I do not need to file a claim. By law, physicians or other suppliers must file claims.

- Q: So that was pretty easy to find?  
A: Yes.

Question E. [Note: very quickly scans and moves back through the pages.] We have the right to change your premium...let's see with a new table of rates, an increase in your age, or a change in Medicare's benefits. And they must notify you 30 days before the change.

- Q: Again, pretty straightforward?  
A: Very straightforward.

Post-test Interview: Policy B

- Q: You didn't seem to have any trouble anywhere in there.  
A: Well, the headings stood out quite nicely. That helped me. It made things easier to find.
- Q: So you didn't think anything was particularly confusing?  
A: No, I thought it just kind of said it straight out.
- Q: So you thought the headings were helpful and the size of print?  
A: Yes, it's easy to read.



Q: Do you have a Medicare Supplemental Policy? Do you ever refer to it when you have a medical claim?

A: Well, we have had to refer to it a few times and we've had to learn about it from other people. Otherwise I don't really look at it.

Test #2: Policy A

Questions: D, E. and F

Question D: Smaller print. Much smaller print. [Note: starts by scanning the pages, beginning at the front of the document.]

Q: As you go down are you mostly looking at the headings?

A: Yes, because I can see them better, yes (laughs). [Note: slowly scans through pages front to back.] Okay. They will pay the initial deductible for the benefit period when you're in the hospital. That's part A.

Q: What about part B?

A: Okay, Medicare pays for Part B services and supplies and we will pay your calendar year deductible. 20% of Medicare eligible expenses.

Q: So they pay your deductible?

A: Yes, but this is much more difficult to read with my bifocals.

Question E: [Note: starts looking through the policy before I finished reading the question.] Well, that's no so easy to find. [Note: quickly scans through pages.] Skilled nursing facility—we will pay the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a benefit period for post hospital... If Medicare pays the first 20 then they pay up through the 100<sup>th</sup> day. Under part A.

Question F: [Note: goes all the way through the document.] They will pay for accidental injury, I don't see anything else.

Q: Are you looking mostly at the headings again?

A: I'm trying to see what the headings are. They have some words that are in black.

Q: The bolded words?

A: Right. I haven't found it. It's not jumping out at me anyway. I'll go back to the front again. [Note: looks at TOC.] Should be under *Benefits* on page 3. Medicare eligible expenses. It doesn't say anything about it. It doesn't say that. It's difficult to find. It's not jumping out at me there—I'm not finding it in this section. I don't see it. Probably because I'm skimming too much but I'm not finding it. As I say, it seems like it should be right there on page 3, it should tell what is being paid for.

- Q: Would you assume that it is or isn't being covered?  
A: I would assume it isn't, because they certainly wouldn't cover anything that isn't there.

Post-test Interview: Policy A

- Q: What gave you trouble in this document? You mentioned the print.  
A: I think it was difficult to read.
- Q: Because of the size?  
A: Right.
- Q: How about anything other than the size if you compare it to the other document?  
It is designed quite differently.  
A: Yes, they are quite different. I thought the other was good because of the columns—I guess you would call it. It was easier to find thing [in policy B]. I could find thing in that one easily. This one [policy A] was quite difficult.
- Q: The headings? Were they better in the first than the second?  
A: Yes, definitely.
- Q: How about the way it was written? When you found the information, was it written clearly?  
A: No, I do not think so to the extent that I could read it and understand it.
- Q: Was it more confusing? More insurance kind of talk?  
A: Yes. And in one place it says Policy Provisions, but you have to then go someplace else. It makes it more difficult to have to go back and forth from one place to another.
- Q: I noticed you used the TOC. Was that helpful?  
A: I didn't find what I was looking for there, but what they do have does seem to be on the page they say. But then again it is hard to read the index.
- Q: Did you use the TOC on this one?  
A: I guess I didn't look at it. I'm not really a person to look at an index
- Q: Any other comments about either one of the documents?  
A: Overall I liked that one [policy B] better than this one—easier to read, easier to understand, easier to find.

**Pre-Test Participant Questions**

**Name:** Dutch

**Age:** 76 y/o

**March 28, 2001 at 1:30 p.m.**

**Q:** Any hobbies?

**A:** Yes, golf, woodworking, reading I suppose.

**Q:** Your wife said you like to travel.

**A:** Yes, travel, camping. We had all sorts of campers but we don't have any of that now. We're at an age when it is better to just go and rent a condominium or something and stay for a while. We go to Florida in November and then we usually go out to Arizona in March. She's got a sister out there, we stay with them. In the Mesa area.

**Q:** Do you exercise?

**A:** Yes, we—both of us have just had cardiac problems.

**Q:** Well she mentioned hers, did you have also?

**A:** Yes, I just had mine ten days before hers.

**Q:** Did you have bypass also?

**A:** No, I just had angioplasty. We're the only couple that attended cardiac rehabilitation at the same time. But because of that we do quite a bit of exercise—quite a bit of walking. We've got a treadmill downstairs.

**Q:** Do you read the newspaper daily.

**A:** Yes.

**Q:** Do you watch TV regularly?

**A:** Yes. I watch too much TV probably. I like history channel, sports, good drama. Following the tournament. We're both from the University of Iowa. But our kids—two of them went to Iowa State and one went to Iowa. But we—I go to a lot of Iowa State games.

**Q:** Do you belong to any clubs or organizations?

**A:** Just Kiwanis.

**Q:** I assume you are retired?

**A:** Yes.

**Q:** What did you do?

**A:** Structural engineer at DOT.

Q: Do you stay connected to engineering at all?

A: Not connected that much now—I read engineering magazines.

Q: How long have you been retired?

A: Since '88.

Q: How about your vision? Do you have problems with your vision? Do you have cataracts?

A: I've had cataracts.

Q: You've had surgery on them? Both eyes?

A: Yes, both eyes.

Q: And it came out well?

A: Yes. Well, I take drops for glaucoma.

Q: But you don't require large print?

A: No, I can see better now than before I had surgery. I don't really need glasses now. I wear them more to protect my eyes more than anything.

Q: You mentioned that you had angioplasty. Any other health problems? Are you healthy otherwise?

A: I had back surgery in October.

Q: Did that interfere with you rehab, your exercising and all?

A: No, that was just something that had been progressing. I did something foolish in the back yard and had terrific pain in my back. They decided I had a nerve that was being pinched so I had a laminectomy.

Test #1: Policy A

Questions: D, E. and F

Question D: Who pays the Medicare deductible part A? It's on this first page or somewhere else?

Q: Well, it is somewhere in this document. Note: looks at TOC first and doesn't seem to find what he is looking for. Then very methodically goes through page 1 and 2.] Are you skimming headings or reading?

A: I'm just kind of scanning. [Note: looks at definitions.] "Sixty additional days of hospital benefits which are available under Medicare part A." [Note: continues to read from definitions.] "This is the amount you must pay each calendar year before benefits can be paid under part B." It's talking about the deductible but I don't see where it says definitely part A. [Note: reading section A on page 3] "Medicare part A not paid by Medicare. It's all about part A.

Q: Nothing about a deductible?

A: It should be before I get back here I think. It should be in this area here [Note: refers to section A] But isn't.

Q: That's an okay answer.

A: Definitely you assume they will pay anything above a certain amount and the deductible would be paid by us.

Q: Then you would expect the part B to be in there too.

A: Part B to be in this right here. Benefits to part B. And Medicare pays for part B. "If you are not enrolled in part B then we will pay benefits as if you were enrolled." [Note: reading from the correct section.]

Q: It's not obvious then?

A: It's not obvious to me. Is this an actual policy?

Question E: [Note: looks at TOC first.] There should be something on page 3. [Note: looks at definitions. Scanning the definitions.]

Q: Again are you looking mostly at the headings or bolded words?

A: I started in there [the TOC] and saw something about skilled nursing. Page 3—it should be right in here. [Note: reads more carefully and slowly down the page.] Well, I don't see anything that says that. Well, there is stuff here about accidental injury. ...skilled nursing facility for at least 60 consecutive days. [Note: reads from definition under *Benefit Period*.] I don't see anything about where it says... It ends when you have not been in a hospital or skilled nursing facility for at least 60 consecutive days. That is the benefit period. Skilled Nursing Facility Care—here it is. We will pay the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day.

Q: So Medicare would pay the first 20 and they would pay through 100?

A: That's what it sounds like to me. All this is goes under Medicare part A.

Q: So it looks like they cover 21 through 100 then?

A: Yes.

Question F: [Note: goes back to the TOC first. Looked carefully over TOC and then just starts slowly scanning the document.] I don't see anything in the front reference.

Q: If you had this question and didn't find anything in the table of contents and I wasn't sitting here, what would you typically do?

A: I would scan through here and look at these titles here. I don't see anything in there that says whether... I'm sure the doctor. The doctors here take what Medicare will pay.

## Post-test Interview: Policy A

Q: Any part of it that caused you trouble?

A: All these insurance policies give me problems. They really do. I am very suspicious of any of these and usually what I do is go to my lawyer or go to somebody else that knows something about. Like I say I have two long term insurance policy that I hope will cover us. And our supplemental insurance is with B. And I have so much paper work. I have volumes of papers, especially since we've had these heart problems—and our medications. And on medications and where I get reports from them and they will pay 80% of this. I get this slip of paper and then I match the two. And if they match I'll throw one away and say "verified" on the other and put this in my notebook. But as far as me knowing exactly what's covered in my supplemental policy I know enough but I don't know as much as I possibly should and I would be scared to death if someone else came along and said "here, this is better than ....." Will you change? I would say no because I would be scared that I would be giving away something in my policy. Even though it is expensive.

## Test #2: Policy B

Questions: A, B, and C

Question A: [Note: goes to the TOC and then to page 3.] Well, let's see. Okay. [Note: reads page 3 then goes back to page 1.] With the addition of benefits for medically necessary emergency care outside the United States.

Q: So, it will pay?

A: It would cover. [Note: reads from the *General Benefit* section, but not the section that gives specific details on this coverage, so did not get complete information.]

Question B: [Note: does not look at TOC. Starts on page 1 and scans down the page moving finger over sections of text.] It looks to me like if a doctor doesn't accept the Medicare amount..."if your provider does not accept assignment we send our payments to you and then you just pay the doctor."

Q: So would you have to file a claim with them?

A: I don't think you'd have to file a claim. You do not need to file a claim. [Note: found the right section but didn't go through it completely.]

Question E. [Note: just starts slowly scanning through pages looking at headings.] Premium changes. It's on page 10. The right to change your premium...yes they can change it but they just can't change yours. They have to change the whole group.

## Post-test Interview: Policy B

Q: How would you compare these two documents?

A: This one is much easier. Because it is laid out better I think. The headings, larger print. It's just easier to read. It doesn't look like it is that complicated. There is a title and underneath it is...

Q: The headings pretty much tell what is underneath?

A: Yes.

Q: So you scanned through both documents. As you scanned through this one could you find information more easily?

A: I could, yes. Of course this is very similar to the one I've got.

Q: But do you refer to it often?

A: No, not really. But I did at one time. It's just that I've become acquainted with... For example when I had that back surgery. I wanted to make sure that I had the approval of \_\_\_\_ to get that. So I called them up and told them what I was going to have and asked them if they would cover that and they said yes.

Q: So, often if you had a question you would call them?

A: Oh, yes. I'd look in here and if it didn't say specifically I would just call \_\_\_\_.

Q: How would you compare the documents?

A: There's too much here [looking at document A as he compares them] that is written in bold—you and we and all this stuff. You wonder why this was all put down there like that. Here's the major title you expect to find in this one chapter [back to document B] and then this goes into more detail about what this says up here.

Q: So this first part lets you know what you are going to find on that page?

A: Yes.

Q: You think that is helpful?

A: Yes. Here's this thing about after the 20<sup>th</sup> day. Written right out. I couldn't find it there [in policy A]. Just skimming through here I could find it.

## Pre-Test Participant Questions

Name: Fanwell

Age: 90 y/o

March 30, 2001 at 10:00 a.m.

Q: What are your hobbies? Obviously I know you write.

A: Well, of course, I'm not a professional writer. See I was an appraiser for the highway department for a period of years—retired from that in 1976 when I was 65.... That was the retirement age—mandatory at that time. My work then was making narrative appraisals of properties that they had to deal with in building the interstate system, for example in widening the primary system. So I wrote about 2000 narrative appraisals, which is a particular kind of writing. You know the definition...you write it so that the person reading it comes to the same conclusion that you come to. That's a summation of what your object is. [Told story about this job.] That kind of writing was my work. Then I retired—you talk about hobbies—right at the beginning of the bicentennial. Because I grew up here, born here, I began to give talks on the history of Ames. Because I did that, I started to write stories about Ames. Because I did that I put those together in book forms two or three times. So I wrote two genealogies and two histories. I don't know how you would look upon my writing. I have my own style. I've been told they don't change it—the paper doesn't change. I have a certain way of writing—you can tell that I wrote it I guess. [Talked more about his writing. Gave distinction between journalism and English writing.] I guess my hobby is right in that area. I write things that are sometimes not even written for publication. I just write them because I want to make a record of it. For example, I wrote this one recently. I had it in mind for a long time—"The Injunction that Wasn't." It's the errors that were legally made in the process of a court case in Story County that went all the way to the Supreme Court. And after the Supreme Court sustained part of the District Court's decision and reversed part of it, it didn't mean anything because of a series of errors in land descriptions. And I knew—I had been in on the original—well, I had been an owner of the property...but I was a witness. [Told the rest of this story.]

Q: You obviously spend a lot of time writing, do you travel?

A: Well, since retirement, we've been to both coasts more than once. My ancestry came to Ames from New England—from Vermont, and so I think we made eight trips. Sometimes we've stayed up in that area as long as a month at a time and made friends up there as well as getting information. I spent a lot of time in courthouses, libraries, you name it. I know in the little home town where my grandparents came from.... Right after the Civil War—1869 they came to Ames, and I'm in the library there frequently. And if I get back there I'll be there [in the library] again. [Tells story about the small town.] That's my hobby.



Q: I normally ask people if they read the newspaper daily. You obviously do, since you appear in it quite frequently.

A: Yes, I read the papers quite thoroughly. I scan them for the things I'm interested in and the editorial page is where I go first.

Q: How about TV? Do you watch TV much?

A: Not too much. I like some of the magazine programs—the special programs. You know what I mean. That type.

Q: Are you a member of and active in any clubs or organizations or do you serve on any committees (such as church committees)?

A: Kiwanis Club, I have been for 60 years a member of the local Kiwanis Club.

Q: You said you were a retired highway appraiser, but you did other work?

A: Before Highway appraiser, I was insurance. And I don't know how to correlate that except to make two points: 1. The insurance business appealed to me from the standpoint that I believed in what I was doing, but I disliked the process that seems to be predominant—or has become predominant anyway. I don't fit that realm quite well. But the real estate appraisal had something in common. Because I was calling on people, property owners, and in reality was the person who would tell them what was going to happen, where the line was going to be....many evening appointments, which I had had in the insurance business. A very close parallel—at night I went to bed feeling very much alike in those two areas. And I thoroughly liked going through the documentation—the process of documentation. To sum that up, when you write an appraisal, you gather your data first, you are actually preparing yourself to prove your point. [Told story about being in court.] My wife says she likes to hear me talk about it. You get a little bit depressed when you're 90 years old. You do. I do. Then I go back and talk about these cases and my wife lets me do it. And it makes me feel good. The feeling I had when it was over with. There were times when I was told afterwards that my written appraisal was passed around so everybody could read it themselves. To me that meant they had confidence in the way I stated it. I used to be over prepared. My great fear was that when they cross-examined me, am I going to be able to pull that information out.

Q: Any problems with your vision? Have you had cataract surgery?

A: I've had cataract surgery. Right now I'm in the middle of something a little worse. You've heard of macular degeneration. About 6 or 8 months ago I discovered something was wrong. It turned out to be I had a hemorrhage in my right eye, my good eye, my dominant eye. I've had two treatments. The doctor said what I have is the result of aging and I don't think you'll have a problem. But then I did have a problem. You see, I had a hemorrhage. I went from 20/20 to 20/70 in days. Just day before yesterday I went to the doctor to say something was wrong.... I tested every day on the chart. I went over there once before and they said that you have tears. I persisted and I went back and it started to bleed again. So they called

today to set up for another treatment. It's a new treatment.... [Told more about treatment.] Now I've had two treatments and I'm going to have my 3<sup>rd</sup> one. And so, for example, I can't see all of my mistakes. I'm not as good a proofreader as I was. Yes, I can read. The difficulty and the result is that I highlight.

Q: Are you still able to read okay?

A: I can. I can still read the paper. The result is that I highlight. I don't read the whole article. I scan. The part I talked about that I don't see—if I get an extra letter, a double letter, I'm going to miss it. This eye (left eye) is still running just barely short of 20/20. This hasn't discouraged me. My dad had problems with his eyes 10 years younger than I am now.

Q: Do you live alone? Do you still drive?

A: [Revealed earlier that he lives with wife.] [Still drives.]

Q: How would you describe your general health?

A: I had a physical about 60 days ago or less and the doctor—I got the lab report and he wrote "everything is great." That was his word. Now one or two things that I look at and I think, well, that was too high. So I asked one of my doctor friends and he said well at 90 that's not too high. You'll be 110 before that gets too high at that rate.

#### Test #1: Policy

Questions: D, E, and F

Question D: Okay, I'm supposed to find the answer. Who pays the deductible? *Right to Return*. Now here we come. I have the habit now of looking at headings. *Policy Term and Renewal*—I see the answer is not going to be there. *Notice to Buyer*—now that might be. *Benefits*. *Important Information*. [Note: looks at TOC at this point.] *Coinsurance*, page 3.

Q: So you are a table of contents user?

A: I guess I am. I don't know. 1-2-3. Benefit period—helps pay for most but not all of the services....

Q: Is that print difficult for you to read?

A: Just a little bit. It certainly slows me down. My mind has to think what have I already read here. ...help you pay for Medicare. When benefit periods begin... Your question is who pays. Okay blood deductible—we pay. We pay under Medicare parts A and B for the reasonable cost of the first 3 pints.

Q: They do it for blood, do they do it for straight Medicare deductible?

A: Now we pay the coinsurance amount of Medicare eligible expenses under part B regardless of the hospital confinement subject to the Medicare part B deductible.

We pay all of the Medicare part A inpatient hospital deductible amount per benefit period. We're talking about in hospital.

Q: So they do pay for part A, how about part B?

A: We will pay all of the Medicare part B deductible amount per calendar year regardless of hospital confinement. In other words, you may not have been confined in a hospital and still they will pay part B. Well, there's the answer.

Question E: Skilled. [Note: turns to the next page.] *Services not covered. Your benefits.* Now we're never in the hospital with this?

Q: Well, you are at first, this is after the hospitalization.

A: Well, those are not apparent coverages. I don't see anything yet concerning--- *Nonassignment...Governing Law...* Well, the question is who pays for skilled nursing and I haven't seen the word. These actually don't apply. [Note: referring to *Your Policy* section.] Must have been before that. [Note: goes back to page 1.] Home health aides...hospice. *Benefit period.* Actually, Medicare is paid through the office up there so I don't—I'm not reading these things. I have a condition in my right hand that you talk about with older people. It's trying to cramp up right now. They call it carpal tunnel. It's gone now. Benefit period starts over when you reenter a hospital—that's a hospital. I'm not finding an answer. But it's probably a reflection on me. Medicare part A. Again, you're in the hospital 10 days then skilled nursing in a place approved by Medicare—in a nursing home or in the home. Well, right now I would have to say I don't find the answer. Shall we stay at that?

Question F: I didn't see anything that indicated that it did.

Q: And you went through it fairly thoroughly? [Note: seems to be getting a bit tired of reading.]

A: I didn't see anything to indicate that it did. Well, maybe now I'm the one that's flunking.

Post-test Interview: Policy B

Q: As you were going through it, and you went through it pretty carefully, any place or part that gave you any trouble? Any thing about the design that was confusing?

A: Well, no I would answer the question in part by saying I would have a better answer had I seen a number of such contracts. Now in my father's day, I took care of his insurance. No institution did. He was in a nursing home. My parents were together in Iowa Lutheran Home in Madrid for seven years. And I found coverages that nobody else found. Afterwards I went back and got them paid.

Q: By going back and studying the policy?

A: Yes, in one or two cases by determining the definition. In other words, when is cancer. My mother had the cancer many years earlier that was cured with radium. Before she died she had a return of...it was not cancerous but it was a result of the cancer, you see. Okay they turned down the claim because it wasn't cancer. And I said it was the cancer. So I went to her doctor and I said why did this happen. It was because she had cancer some years before. If she hadn't had that she wouldn't have gotten this. So I got it paid. Well, I don't know what I'm missing here exactly. But I remember how I went back to Dr. Rosebrook, remember him? And he said you're right. So he wrote a letter and I took it to Des Moines and I got the money.

Q: What parts of the document were particularly helpful? I noticed that you looked at the headings, were they designed pretty well done? Did they tell you what was coming after? And the table of contents—you used it. Was the table of contents helpful at all?

A: Well, they are always helpful but, for instance, I didn't find one that took me to hat answer. Nothing that I thought would take me to that answer.

Test #2: Policy A

Questions: A, B, and C

Q: This print is much smaller, will you be able to read it?

A: Yes, I can.

Question A: Yes. Oh, boy. Okay. *Exclusions and Limitations*. Okay. *Agreement*.

Benefit period. Hospital. Skilled nursing—there's that word. [Note: reads down the TOC.] Well, I've got to go to page 4. This must be 4. I'm in Italy—foreign country. Okay, Emergency care in a foreign country. We will pay for care received in a foreign country as follows: you pay a calendar year deductible of 250 then we pay for 80% of the billed charges for Medicare eligible expenses for medically necessary emergency care. Does that answer your question?

Q: So you went to this section after looking at the table of contents because you thought it would be under what?

A: Well, *Exclusions and limitations*—claims are on the same page. I figured xclusions—if they didn't pay in a foreign country, that's where they're going to say it.

Question B: It's on the same page. *Payment of claims*. On all claim matters contact A—it's there with their address. You must give us written notice of a claim. The notice must identify you and your policy. Claim form—there's the answer.

Question C: [Note: looks at TOC.] Well, *Agreement*, page 3. It's going to be one page ahead of where we were. *Definitions*. *Benefit Period*. The question is can they

raise the premium? *Definitions*. Medicare and calendar year deductible. Well, I'm pretty sure it's in there somewhere but I don't see it there.

Q: Is that where you think it would logically be, under *Agreement*?

A: Yea. It said agree to pay you benefits for Medicare eligible... while this policy is in force. Payment will be on the same basis for either sickness or accidental injury. Benefits will change automatically to coincide with any changes in Medicare. It doesn't say anything about premium changes, it's benefit changes. Okay, now we agree to pay in return for your premium payment to insure you subject to all the terms of this policy and in reliance upon your application which is made a part of this policy. Now that application may have had some words in it. [Note: moves to page 2.] Please read this policy carefully. *How to File a Claim*. Health Lines. Well the way I went at it, I don't find the answer to that question but I wouldn't guarantee it is not there somewhere. Pay each calendar year before benefits can be paid. Calendar year deductible is the amount you must pay. I would have expected it to be up under *Agreement*. We agree with you in return for your premium payment to insure you. The only thing it talks about changing is benefits. *Additional Benefits*. *Exclusions and Limitations*. It shouldn't be under there. [Note: going through and looking at major headings.] It shouldn't be under *Payment of Claims*. *General Provisions*—it might be. [Note: starts reading at beginning of *General Provisions*.] In the application—on the basis of the statements and agreements in the application. Premium payments in advance will keep this policy.... Effective date until the first renewal date. The premium is set out in... each renewal premium is due on its due date subject to the grace period. *Contact*. *Suspension of Coverage*. *Grace Period*. This policy is guaranteed renewable... now here's where it might be. It's guaranteed renewable for life subject to our right to change rates. There's the answer.

Post-test Interview: Policy A

Q: What do you think about the way this document is written and designed? Any comparison of the two?

A: It's a little difficult to just come right out and say well this one is a little better. To study them equally...

Q: How about for someone just sitting down and moving through them. Could you move through A just as easily as B?

A: Well, in one sense I moved a little better through this one (A).

Q: But you did find all the answers in A and a little trouble finding some of the answers in B?

A: Yes, for whatever that means.

Q: But you kind of went through them both the same way. You looked at the table of contents and looked at the headings and tried to figure out what was logical for you?

A: I tried to go through

Q: Did your vision bother you with this one?

A: Probably, because you know while my vision is not distinctly blurred, it has the effect of being blurred. The effect is that this one is fighting this one. They are not together. Size of print. I think the print is a little smaller.

Q: Are the headings clearer?

A: Well, I think they are both good. Well, they are both good but these stand out more distinctly [policy B]. I might change my mind if I were to be specifically involved in a claim. Like the ones I told you about. Heaven knows how much time I spent on those. In that case, part of what I was talking about was interpreting what I read. And a part of it was discussion with the doctor and the doctor realizing that I was right in interpreting. I haven't been in the insurance business for a half of century. But I remember that even in the case of fire insurance the interpretation. We had a bad storm and the roof was damaged and I had to have it resingled. The terminology even the insurance company couldn't understand. It was the difference between repair and replacement. I came up with the conclusion that there is a difference between repair and replacement. They were being interpreted as meaning the same thing and I said they mean different things. Replacement is replacement in kind and similar identity. I won that one. I know the words have a part in insurance companies changing their documents eventually. One of the best life companies in the world [told story about interpretation] See I'm not sharp enough now to apply that to this but I think that is involved in any of these how you interpret, how you read it, how you see it. There's one word in the field of insurance. It's a 50cent word..

Pre-Test Participant Questions

Name: Vic

Age: 75 y/o

March 30, 2001 at 11:30 a.m.

Q: What are your hobbies? What kinds of things do you like to do now that you're retired?

A: I'm quite active in our veteran's organization, the China-Burma-India organization. I do a lot of reading—history. I travel.

Q: Play cards?

A: No, I'll probably get into that. I've been here almost a year now and I will probably get into that since they do it here a lot. I did historically and then I dropped out.

Q: How about exercise?

A: Yep. We have exercise here for two periods Tuesday and Thursday morning from 8:30 to 9:15 and then I walk two miles a day.

Q: Any volunteer work?

A: Yes, I work at the hospital—the front desk. Yes, from 12 to 3 on Mondays. I did deliver Meals on Wheels but I quit that.

Q: Do you read the newspaper?

A: I read both the Register and the Tribune.

Q: Are you a TV watcher?

A: Yes, JAG is a program that I watch, and then of course the news. And then athletic football and basketball.

Q: You mentioned you are active in the veterans group. Any other clubs?

A: Lion's Club.

Q: You retired as a professor, do you stay connected to your former profession in any way?

A: Professor Emeritus of Industrial Engineering. There is a central Iowa chapter of our Industrial Engineering and I attend meetings and get the publications. But I don't do consulting any more. I did for a few years after I retired. I retired in May of '91.

Q: How about your vision? Any problems with your vision?

A: No.

Q: Have you ever had cataract surgery? And as far as you know, no glaucoma, no macular degeneration?

A: No. No.

Q: You don't require any large print?

A: No

Q: Do you live alone? Do you have family close by? Do you still drive?

A: Yes, my wife died a year ago this month. [Lives in a retirement complex.]

Q: So is that when you moved in here?

A: Yes. I was the first one here, April 30<sup>th</sup>. I have a son in Ames and a daughter in Minneapolis. [Still drives.]

Q: How would you describe your general health?

A: I have a heart rhythm that I'm taking medication for. That's the only medication I take.

Test #1: Policy A

Questions: A, B, and C

Question A: This is a plan that is issued by a private company? So what Medicare doesn't cover they attempt to cover? You want me to speak is that it? I'll see if there is anything on out of country. Medicare doesn't pay for anything out of the country. [Note: starts by a brief scanning of all the pages.]

Q: Do you scan the headings?

A: Yes, I'm seeing if there is anything from out of country. I guess first here—I don't see anything on foreign coverage on the first pass through. [Note: looks at TOC. Then went more carefully through the document again and looked closely at *Exclusions and Limitations*.] It says here that "payment that has been made or can reasonably be expected to be made, under a worker's compensation law or plan of the United States or a state. Now this indicates this but it doesn't mention anything about foreign illnesses or if you're traveling, or on a business trip or whatever in a foreign country. It doesn't specifically state that. If it does it is rather well hidden. These policies do have a lot of detail. *Suspension of Coverage*. If you become eligible for medical assistance under Title XIX of the Social Security Act, your policy benefits and premiums shall be suspended for a maximum of 24 months—that's different. I don't see anything specifically. I guess I would have to call then and ask for information about that.

Question B: I guess normally in my case the doctor's office has my Medicare number. I have a supplemental policy. BCBS of Iowa. I pay for it myself.



Q: They may well say that you can do that too. I guess I would like you to see what they say.

A: How do I can file a claim for a visit to the doctor's office. [Note: looks at TOC first.] *How to file a claim*—page 2. Present your insurance card to the doctor. Ask the provider to send us a copy of your "Medicare Explanation of Benefits" statement they receive from Medicare. If your medical provider does not submit claims to your insurance, simply list your policy number on the Medicare Explanation of Benefits statement and send it to us. Unless we have an authorization to pay those who provided your service, payment will be sent directly to you. I guess I would start with that. That one was pretty straightforward.

Question C: When can they change it? Okay. [Note: looks carefully at TOC.] There's contract changes on page 5. Now if we want to do what now? Can they ever increase? When can they do that? The length of time. "This policy is guaranteed renewable for life subject to our right to change rates and subject to you remaining an Iowa resident. Renewal requires payment of premiums when due at the rates effective at renewal dates. We may also change the rates for this policy form for future renewals. Rates will be based on attained age, sex and... Okay, well, I guess this is it then. And once you take it out for a year, they won't change your premium that year. That is the impression I get, but it could go up with your next payment.

#### Post-test Interview: Policy A

Q: As you scanned through it, any areas that seemed to be difficult or confusing?

A: No, I don't think so. It's good enough to—it has to be legally sound and sometimes those aren't written for the average person to look at. I think it's enough as long as you have an 800 number or a local agent that you can call for details.

Q: Any thing about the way that the document is designed that is particularly helpful?

A: I think having this right on the front page is good. [Talking about the TOC.] That you can—*How to File a Claim* that was really good. I think it's good to have it right there.

#### Test #2 Policy B

Questions: D, E, and F

Question D: Okay, Medicare part B. Now, part A—I guess...one is hospital and one isn't. [Note: looks at the TOC and then goes to page 1.] Yes, Medicare part A pays for inpatient hospital care, skilled care [reading from page 1]. We offer you supplemental benefits in all of these except for hospice. And Medicare part B pays for physician services, outpatient services and supplies. We offer you

supplemental benefits in those. So I guess both part A and B Medicare would take the first part.

Q: But there is a deductible for Medicare, does this policy cover that or do you have to pay that?

A: Yes, there is a deductible for Medicare. I guess my assumption has always been that Medicare would pay all or part of it and then what they didn't pay your statement would go to your private carrier, supplemental carrier, and they sometimes doesn't cover everything either.

Q: So you would assume then that that would cover the deductible, but they don't really say that?

A: They don't say anything about the deductible in here. I'm not sure what the deductible is.

Q: Each year I think there is a deductible you pay before Medicare starts covering.

A: Before they start covering? I wasn't aware of that. I just—[Note: scanning pages.] Let's see...we pay all of the Medicare part A inpatient hospital deductible amount per benefit period. We pay the coinsurance amount of Medicare eligible expenses under part B subject to the Medicare part B deductible.

Q: So does it cover it?

A: Yes, but I have never gotten into that. I guess I wasn't aware they took some off. My policy must cover it because I've never had to know about that.

Question E: [Note: begins by scanning headings through the pages reading headings.]

Medicare covers the first 20 days. I know there is a problem with that. *Services Not Covered*. I don't see anything on skilled care specifically. [Note: goes to TOC.] This talks about foreign country. The first one didn't. It might be *Nursing Facility Days 21-100*. There is a limit on how many days of hospital or nursing facility care Medicare helps pay for in each benefit period. Medicare will help you pay for medically necessary services when you are an inpatient in a hospital for more than 90 days. If you are in the hospital for more than 90 days then Medicare offers 60 lifetime reserve days you can use to help meet expenses. Benefits begin the first day you enter a hospital or nursing facility...after you have been out of the facility for 60 days. It doesn't mention skilled care. I imagine that would be very similar to what they talk about here for nursing care. I don't see skilled care anywhere. [Note: looks back at TOC.] No, I guess I don't. I would have to dig a little deeper. Nothing in here about skilled care, unless they use different terminology.

Question F. Nursing facility 21-100 days. Hmm. Medicare part B helps pay for physician services...and it lists all of these categories. I assume a doctor's visit is covered there. When a physician or supplier agrees to accept the charges for

Medicare, and most of them will, he will collect for services. I would assume that they would cover the balance.

- Q: I noticed you read that in the table of contents. Do you think that refers to s skilled?
- A: Nursing facility? It is kind of hard to determine what that includes. Just what they mean by that. I guess I would have to call and dig deeper. The table of contents here is not as easy to follow...is not as complete as the other one.

Post-test Interview: Policy B

- Q: How would you compare the two?
- A: The table of contents here is not as easy to follow. It is not as complete as the other one [policy A]. The other one it might be a little easier to find what you want in it. It's a little more complete in finding what you want. This one [policy B] is easier to read but it is not as complete. But I think on a lot of these if you have their 800 number that a person goes through it and it if doesn't hit them right in the face that they will call. I just assume that Medicare takes the first batch and then my supplement will get it without my intervention. They just do it automatically. And then if it is not covered, I'll sometimes check. I'll call Wellmark and say well now Medicare didn't cover this completely and you people haven't covered the balance completely. What's the reason? And there are some cases, not many, where the supplement will not take care of the balance.
- Q: Yes, and that would be the time when you would need to understand-either trust what they tell you or be able to look it up yourself.
- A: Right, at that time. And normally I don't get involved any more than I have to. And that's only when the total cost is not covered. There are cases like that. In fact I have one still going on. My wife had cancer and was in a wheelchair. And there was some question—she had a doctor's request for a wheelchair and Medicare hasn't covered it and the supplement hasn't covered it. I should probably call Medicare and ask about it. And Wellmark, I don't know if I called them specifically or not.
- Q: Any other comments about the way this is written? When you did find the information, is it readable?
- A: It was quite general but I guess I appreciate that they have to be fairly general. It would be good if they had in here the number to call if you have any questions. [Looking through document for number and then looked on back cover.] Right up front. But here I guess they have them here...well, they have the office but not the phone number. I thought there was a number somewhere on this one [looking at policy A]. Yes, right here but it is not an 800 number. Yes they should have the number.

Pre-Test Participant Questions

Name: Bottle

Age: 75 y/o

April 2, 2001 at 2:00 p.m.

Q: Any hobbies?

A: Woodworking; fool with the computer.

Q: Travel? Play cards? Anything like that?

A: We generally go to the south or the west for winter. We just got back from Arizona—the Phoenix area.

Q: Do you exercise regularly?

A: We go to—we try to go twice a week to the exercise program that have here at the place. It's not real strenuous but we try and do that. We try to do some walking too but we're not too faithful.

Q: Do you do volunteer work?

A: No, I don't really.

Q: Do you read the newspaper daily?

A: Daily, yes, we do the Des Moines and the Ames paper both.

Q: How about TV, are you a TV watcher?

A: No, my wife is but I'm not.

Q: Are you a member of and active in any clubs or organizations?

A: Just the Ames Woodworkers Club.

Q: What kind of work did you do?

A: I was a faculty member at Iowa State in Industrial Engineering. Retired in '87.

Q: Do you keep connected in any way to the profession?

A: No, not really. I don't really keep connected in the professional way, no.

Q: How about your vision? Have you had cataract surgery or do you have cataracts?

A: No, no.

Q: No glaucoma or macular degeneration?

A: No.

Q: So you have pretty good vision?

A: Very good. Vision is very good.

- Q: [You live with your wife.] Do you have family close by? Do you still drive?  
 A: We have a daughter in Ankeny and her family, and our son is in Denver. So, I guess that's close by. He's been in Belgium for 3 years before that so this is close.
- Q: Do you still drive?  
 A: Yes.
- Q: How about your overall health?  
 A: I have blood pressure that every once in a while goes on up. I take medication for it.
- Q: Any other health problems?  
 A: No, I don't think any other problems.

Test #1: Policy B

Questions: A, B, and C

Question A: Now are you talking about just the first page or are you talking about the whole thing?

- Q: The whole thing.  
 A: Well, first I would look through and see if it's got a column thing out here [Note: looks at the front of the booklet.] I don't see one that catches me. *Benefits. Benefit Period* [Note: looks at the TOC.] I suppose it would be under that one of benefits. Okay, benefits. *Medically Necessary Emergency Care in a Foreign Country*. I guess that would be that part under that paragraph. So we'll look back here and find that. Foreign Country. To the extent not covered by Medicare, we pay 80% of the billed charges for Medicare-eligible expensed for medically necessary emergency hospital, physician, and medical care received in a foreign country, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. Yes, they do cover it. And they cover it up to—the first \$250 deductible. That means I would have to pay that much. And above that they would pay up to a lifetime maximum of \$50,000. I hope we won't go up that much.

Question B: [Note: looks at TOC.] Okay, that's a...back to the index here a minute. I'm not sure whether the doctor's office is A or B. One of them is the hospital and one is the other. I believe that it is B. Medicare deductible. [Note: just turned page and saw the section on page 1.] *Filing Claims*. You do not need to file a claim with Medicare for any services. By law the physician has to do that for the Medicare part. You should always make sure that your provider knows that you have supplemental coverage with us. When you receive health services in your home state, Medicare will automatically send your claim to us. Out of state. They'll take care of it.

Question C: [Note: looks to TOC again briefly then scans the pages.]

- Q: When you go through the pages are you scanning the headings?  
 A: Yes, kind of. For a change in.... *Authorized Policy Changes*. You must pay us in advance each year. [Note: stays on page 9 and read it carefully.] Your acceptance of an amendment must be in writing if the amendment increases benefits with an increase in premium. Can the company ever increase the premium charges and, if so, when can they change it. Well, they apparently can change them here. Increase benefits with the increase in premium during the policy period. So I guess they can change them but I.... Well, I don't see it. That's the only thing I see. [Note: never turned to the next page.]

Post-Test Interview: Policy B

- Q: Where in this document did you feel you were having trouble or any part of it that is confusing the way it is written or designed?  
 A: No, I was able to find the first two things right off. So I guess from that standpoint...I didn't have any trouble understanding it.
- Q: So it's written pretty clearly?  
 A: Yes, I think so.
- Q: I noticed that you looked at the table of contents several times, was that helpful?  
 A: Yes, I believe that was helpful to take the amount of time—because I knew the one was back here and that was after all these other things, so that was helpful.
- Q: How about the headings? As you went through are those pretty noticeable?  
 A: I don't know. The one dealing with the foreign country, I guess I caught that pretty quick with that heading. I did have the question and I've been over this a thousand times between A and B and I think B is normally the doctor's. I guess I depend less on my memory than I use to.
- Q: Did these headings stand out pretty well to you with the lines above and below them?  
 A: Yes, because I skipped over some of these things that didn't have the lines.

Test #: Policy A

Questions: D, E, and F

Question D: Now is this the same company? [Note: after question read, looks at the TOC. Reminded to read out loud.] Well, this here I'm just trying to find out how this is organized. Medicare Supplement Plan F. I guess that's the one they sell, Plan F. *Important Notices*. This is a legal contract. Read carefully. Important Notice. The policy is a legal contract. 30 days to examine. *Renewability*.

*Premiums.* A lot of fine print on this one. Now who pays for Medicare deductible for Medicare part A and part B? [Note: looks at the TOC again very carefully.] Who pays the Medicare deductible for Medicare part A? *Benefits.* Well, I guess I would try and go here to page 3 to begin with. Page 3 of 6. *Benefit period.* Expenses of the kind covered by Medicare to the extent recognized as reasonable and customary. Any expense or portion of expense that Medicare considers unreasonable, unnecessary or in excess is not a Medicare eligible expense. This is all definitions. *Benefits. Medicare.* Okay. Now here is something about deductible. *Hospital Confinement Benefits.* That would be the part A. When Medicare pays for your stay in a hospital we will pay your initial deductible for the benefit period beginning with the 61<sup>st</sup> day. Who pays. Oh, my land. [Note: frustrated with policy.] Who pays the Medicare deductible for Medicare part A? Beginning with the 61<sup>st</sup> day. Let's see, when Medicare pays for your stay in a hospital, we will pay your initial deductible for the benefit period. Who pays the Medicare deductible for part A? I would say the insurance company.

Q: Okay, so that is part A? How about part B?

A: Well, there is Benefits to part A. Maybe there will be a heading that says Benefits part B. When Medicare pays part B services and supplies we will pay the calendar year deductible and pay 20% of your Medicare eligible expenses incurred for those Medicare Part B services and supplies and 100% of the difference between the actual billed amount—so they are going to pay the deductible for part B. Oh, my land!

Question: Okay, so I want benefits that cover skilled nursing care. [Note: starts looking on the page where he left off with the last question.] I'm looking here what *Benefits to Supplement Medicare part B.* I would think it would be B. May be charged a non-replacement fee. If you are enrolled Medicare will pay. Emergency Care in a Foreign. *Additional benefits to supplement Medicare.* Medicare eligible expenses for medically necessary emergency care. Well, that's primarily for foreign countries. Well, the daily co-payment amount under Medicare part A for skilled nursing care above the number of days covered by Medicare. Expenses not covered by this policy. No benefits are provided for the daily co-payment amount under Medicare part A for skilled nursing care above the number of days covered by Medicare. We need care for 120 days. Medicare covers all the expenses for the first 20. It says here this does not pay the daily co-payment above the number of days covered by Medicare. So it just covers the same number of days that Medicare does. So it wouldn't be any help.

Question F: Well, it would probably come under Medicare part B. Benefits are payable as follows. When Medicare pays for part B services and supplies we will pay the calendar year deductible and pay 20% of the...and pay for. A...Section A. Benefits to supplement Medicare part A. One is hospital confinement. And 2 is blood transfusion and skilled nursing facility care. Well, skilled nursing care.... Will this policy pay for your doctor's office? I don't know. I don't find it

anywhere. I don't see anything [Note: looked carefully at Section A and Section B.]

Post-Test Participant Questions: Policy A

Q: Where in this document did you feel you were having trouble?

A: It sounds like they are writing it for more of a professional understanding. If you were well versed in Medicare things and insurance things, you could probably do better here. But if you are a user, I don't think this has a very good level—a very good place a consumer can get a hold of it.

Q: Do you think the other one [policy B] was written more for the consumer?

A: It was written more for—it wasn't so legalistic. I think they've got probably a lot of legal things required here a lot of things covered, loopholes covered, that may not be so evident.

Q: They cover the same things.

A: The emphasis here has been on the legality.

Q: What about the print size, did you have any problems with it?

A: Well, I don't know—I don't think that...I don't know. I suppose it could be a little bit, although I don't have any trouble reading this. I can read. It's just got so much more bulk in it. Well, it covers...I don't remember seeing anything about time limits on certain defenses, grace period, reinstatement, suspension of coverage, legal action, misstatement of age...this is so much more...more information. There is more information—Membership voting and annual meeting and I may never attend one.

Q: Maybe more information than you need?

A: Yes, I would think so. It's all you ever need. It's all you ever need. Now that other one [policy B], you may find something short. If you want to attend a national meeting, I don't remember seeing anything.

Q: So perhaps better to have more information?

A: No, I don't think so.

Q: For the average person it would be better to have less?

A: Yes, that's right.

Q: What parts of the document were particularly helpful? You used the table of contents, was it helpful?

A: I didn't find that helpful at all. I didn't find that helpful.



- Q: How about the headings? Did you scan those like you did the other one? They use a lot of bolding, did that help?
- A: I guess I didn't feel like I made much use of that.
- Q: Any other comments about it compared to this?
- A: That one [policy B] would be so much more applicable to my needs than this one would be.

**Pre-Test Participant Questions****Name:** April**Age:** 76**April 2, 2001 at 2:30****Q:** Any hobbies? I know that you two travel?**A:** We travel a lot, yes. I love to read. That's my passion—reading. I like historical novels or about real people. I like biographies of real people that I am interested in.**Q:** Do you play cards?**A:** We do play cards with people here and our friends in Arizona. Same friends here and there, year after year.**Q:** Your husband mentioned that you exercise?**A:** We do the exercise sessions they have here.**Q:** Do you do any volunteer work?**A:** I don't do volunteer work. I know I should, but I do not.**Q:** Do you read the newspaper daily?**A:** Oh, yes, every day.**Q:** Do you watch TV?**A:** Some. I usually watch public TV. I like those. We haven't had cable until we came here. And I like the history channel and discovery. I listened to discovery last night and some of this medical—that's interesting. I like some of the other programs, but I can't even think now what I do watch.**Q:** Are you a member of and active in any clubs or organizations?**A:** Church is our main thing.**Q:** Did you ever work outside the home?**A:** No, I never did—just occasionally. When the children flew the coop I did. I like flowers and I love to work in the garden. And so I worked for Mullica Greenhouse, it isn't even here now, and I worked there until our daughter got married. And she was finishing college and I was working and I only had one daughter and I thought I want to do this and enjoy this. So I quit work then. Then the little grandkids came along. Engledingers had this store—remember that—and I spent half of my money there so I thought wouldn't that be fun to work there. So I did that for a while. I enjoyed that, too. That's all I've worked.

Q: How about your vision? Any problems with your vision? Have you ever had cataracts?

A: No, never had cataracts. No problems.

Q: No glaucoma or macular degeneration?

A: No.

Q: So you read normal sized print without any problems?

A: Right. Yes.

Q: Do you live alone? Do you have family close by? Do you still drive?

[Lives in retirement complex with husband. Daughter in Ankeny and son in Denver.] Your husband told me about your son and daughter. Do you still drive?

A: Yes.

Q: How about your general health? Do you have any health problems?

A: Well, I have high cholesterol. I fight that all the time.

Q: Do you take medication for it?

A: I take Lipitor.

Q: Any other health problems?

A: I take a blood pressure pill. Not a lot but it controls it.

Test #1: Policy A

Questions: A, B, and C

Question A: I have no idea. [Note: scans through the pages quickly reading main headings.] *Definitions. Benefits. Additional Benefits. Payment of Claims. Payment of Claims.* Paid to you unless they have been assigned. I guess I just—very quickly I didn't even see but I'm sure it's in here. I'll go back and start over. [Note: looks at TOC.] *Payment of Claims* under *Claims. Payment of claims.* I guess I really don't just pick up on being out of the country. If it's there, I'm not seeing it as I scan it. I'm probably reading too fast.

Q: As you go through, it's not obvious where it should be?

A: It isn't for me [laughs]. It probably is, but I don't see it. I don't see it. I really don't see anything for out of the country.

Question B: Filing a claim. [Note: looks at the TOC.] Page 2—*How to File a Claim.*

Ask the provider to send us a copy of your "Medicare explanation of Benefits" statement they receive from Medicare. If your medical provider does not submit claims to your insurance, simply list your policy number and send it to us.

Q: So that makes sense to you?

A: Yes.

Question C: Let's see, premium charges. [Note: looks through the TOC then scans the bottom of the first page.] *Payment of Claims*—page 4. Let's see expenses. It could be under expenses not covered by this policy, I suppose. Not covered by... [Note: turns to page 5.] I see about the premiums.

Q: Nothing about changes?

A: We agree to pay you for expenses [Note: turns back to page 3.] I don't find it.

#### Post-Test Interview: Policy A

Q: Let me ask you about the way this policy is designed and written. You used the table of contents. Was that helpful?

A: I think it would be [laughs]. I just don't know much about this sort of thing and I don't—wasn't really sure what I was looking for. It wasn't obvious—the one was, but not the rest, not for me, because I really don't deal in this at all. Bob takes care of everything and I really don't.

Q: When you were going through it, you went through page by page. Were you mostly reading the headings?

A: Yes, and I was looking for certain words. I think if I sit down and really read it, but I was scanning looking for certain words to pop out. And they didn't pop out for me [laughs]. But I think maybe if I had time I probably could figure it out. [Note: seems a little embarrassed that could not find the information.]

Q: The overall design, how was that?

A: Well, it seems logical. Yes, it does. It's all headlined and it's all down here, so I think so. I think if you just simply took a little time you could figure it out [laughs].

#### Test #2: Policy B

Questions: D, E, and F

Question D: It looks better from the outside. Well, I will look for part A. Medicare part A, who pays the deductible, so you look—page 3. [Note: looks at the TOC and then goes to page 3.] So you find it here on page 3, who pays Medicare part A for most but not all of the services you receive. And B pays for some but not all. So then you would have to look through and see what they did pay for, wouldn't you?

Q: Does it say anything about the deductible?

A: As I understand it, part A deductible would be under this, right? [Note: points to TOC and listing of Medicare part A deductible.] And I would assume it's page 3,

so that's where I would look. [Note: reads the information, but doesn't seem to be able to find the answer.] Well, I know who pays it. Medicare will help pay for medical—90 days. Who pays the Medicare deductible? Well, Medicare pays for it, I know that. Your other insurance picks up the rest, I do know that.

Q: But it doesn't specifically say anything about the deductible?

A: But I know that, so I don't know....

Question E: I know what it [skilled nursing] is. [Note: looks at the TOC.] *Services not covered*. I don't think it would be in that. The foreign country would be easy to find in this one. Page 3. *Nursing facility 21-100 days*. There's a limit on how many days you can be in. However, it is possible to renew a benefit period. When your benefit period is renewed, your part A protection is also renewed. Renewing a benefit period means that you begin a new benefit period. Medicare will help you pay for medically necessary when you are in the hospital for 90 days. 60 lifetime reserve days—there you go.

Q: So you would be able to use that to cover it?

A: Yes, you can renew. Yes.

Question F: [Note: looks to TOC.] First I'll see if it's not covered. [Note: goes to *Services not covered*.] Well, it must be covered, because it doesn't really list that it was not.

Q: Since it's not listed under there, you're assuming that it is not covered?

A: I'm assuming.

#### Post-test Interview: Policy B

Q: Now tell me what you think about this policy. How would you compare it to the first one?

A: I liked this one better, frankly.

Q: What specifically? You used the table of contents a lot.

A: It was just easier to see. Exactly what you asked was here. I really had to look and I didn't find on that one [policy A]. But this one seemed to me—it was much simpler for me. It tells you the A and the B. The other you really have to read through a lot of stuff to find out what you're looking for. This one is simplified—or to me it was.

Q: Anything confusing about this one?

A: Not really, I don't think so.

Q: Do you prefer the size of print of this one? Did you have any problems with the other?

A: The size of print was easier to read, but I didn't have any problem with the other one. This is just simplified.

Q: Any other comments about these documents?

A: No, this is more attractive to just pick up.

Q: Do you have a Medicare Supplemental Policy?

A: Yes.

Q: Do you ever refer to it? You said your husband takes care of that?

A: He does all that. I never look at it.

**Pre-Test Participant Questions**

**Name:** John

**Age:** 66 y/o

**April 3, 2001 at 3:00 p.m.**

**Q:** What are your hobbies

**A:** This is John [talking into the microphone]. Tinkering with cars and getting old radios to operate. As well as taking mind expansion courses. [Taking second class for seniors.]

**Q:** Do you travel?

**A:** Not much. We have a daughter in the Chicago area and we take occasional trips there. We have another daughter in The Netherlands and we went over there just a few years ago. We have a dog that will be 18 this summer that sort of prevents us from taking trips.

**Q:** How about reading or playing cards?

**A:** Some reading for information but that's about it.

**Q:** How about exercise?

**A:** Yes, treadmill and weights.

**Q:** Any volunteer work?

**A:** Yes, I'm active in the Lion's club.

**Q:** Do you read the newspaper daily?

**A:** Yes, just the Ames.

**Q:** Are you a TV watcher?

**A:** Watch TV, again for information and the weather channel to see what's going to happen. We have a son at Iowa in Med School so, is it okay to go over there and get back in one day without it being a white knuckle trip.

**Q:** Now you're retired from the university?

**A:** Yes, 30 years on the faculty—May '98 I retired from industrial engineering.

**Q:** Do you stay connected to your profession at all?

**A:** Yes, I continue going to programs at the Central Iowa Industrial Engineering Chapter. They put together a plant tour in February at the Lenox Company.

**Q:** How about your vision, any problems with your vision?

**A:** No, vision is good.

Q: No cataracts starting, or macular degeneration or glaucoma?

A: Right.

Q: And you don't require large print?

A: Right. No problems.

Q: You've already told me about your family. And I just met your wife. [Still drives.] How about your health?

A: I have to watch my salt intake and diet and exercise, I am able to keep it—I guess it would be borderline. 142/70 is my blood pressure. No, knock on wood, I've been okay [no medication] and I've gotten my cholesterol down to 198. But it's a battle because I enjoy food and if it tastes good, there's a question of whether it should be eaten.

Test #1: Policy A

Questions: D, E. and F

Question D: [Note: quickly turns pages. Does not look at TOC.] Okay, *Benefits to supplement*—it's part A you're asking me on, right? Okay this policy on page 3, part one, it says when Medicare pays for your stay in a hospital we will pay and then part A is your initial deductible for the benefit period. Part A is under the section A, statement part A. [Note: turns the page and looks at heading.] Medicare part B. Okay, when Medicare pays for Part B services and supplies, we will pay the calendar year deductible. So they pay the deductible.

Q: Okay, pretty straight forward?

A: Yes.

Question E: Let's see. That's hospital. This was after 120 days. Well, you were in for 10 days, then—well, Medicare pays for that doesn't it?

Q: Well, Medicare pays for some, the question is does this policy help at all?

A: Oh, okay. Okay. *Skilled Nursing Facility*. We will pay the actual billed from the 21<sup>st</sup> through the 100<sup>th</sup> day. That wouldn't cover all of it, would it? The last 10 days wouldn't be covered I guess—Yes.

Question F: Okay, that's under part B.

Q: You just know that?

A: Yes. Okay, Medicare pays for B and we will pay 20% of Medicare expenses and 100% of the difference between the actual—well, they also pay the deductible. If you aren't enrolled in B we will pay the benefits as if you were enrolled.



## Post-test Interview: Policy A

Q: Looking through that document, any reaction to the way it is written or designed?

A: It's easy to follow. Section A they are tying in with Medicare A. Section B they are tying in with Medicare B.

Q: So, it's very logical?

A: Yes.

Q: You seem to go the areas with answers rather quickly. They use a lot of bolding.

A: Yes, that helps. That helps.. They've got what's important in the first sentence, the lead sentence. This other [referring to page 1, 2, and first part of 3] is just boilerplate and I think it is standard with other policies. Is this an actual policy?

Q: Do you have a Medicare Supplemental Policy?

A: We have the university W. Ours is a hybrid, I think. It costs a fortune. They take care of everything at the physician's office.

## Test #2: Policy B

Questions: A, B, and C

Question A: Well, this is the index. This is going to be this section on 3, do you think?

You want me to find it? You want me to find it, okay. Okay, I found the answer on page 5. We pay 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital in a foreign country—deductible of \$250. So the question again was does they cover it? Yes, they will pay 80% of it. And I'm not sure—okay if I was there and this happened to me if I would have to pay them and be reimbursed or what.

Question B: Actually I don't know how to do that because we go to McFarland Clinic and they do the paperwork. [Note: looks at TOC.] Okay, it should be on page 9 then under *Your Policy*. Well, I'm not finding it—*How to file a claim*. Maybe it's under filing claims—that might help [Note: looks at TOC again.] But that's not in the index, is it? It says *Important Information*, so I guess that is important information. Okay, if they don't accept the Medicare.... Oh, okay it says by law physicians or other suppliers must fill out claims for you and send them to Medicare even if they don't accept assignment. Okay that's for Medicare, now how does this work with this? Okay, it says if the information is being sent to your private insurer, we will automatically receive it. Okay, so it can be done by the provider. This happened in Illinois with this and the hospital there took care of sending it in. It sounds like it, but it's not that clear though. You have to send the Explanation of Medicare Benefits to the supplement. You don't need to send a claim form just send the form to the... Yes, I guess it's not that clear. This is implied and maybe the physicians and healthcare providers know this.

Question C: Well, not even reading this I know that they can increase them. And I would assume that it's at the anniversary date. But you want me to find that in here? I know because it's been happening to us because the rates—the policy took effect in February so they raise it every year. Maybe it's under *Important Information*. I don't see it. I guess it's under *Your Policy*. When coverage begins—once we receive your application and so on.... Pay in advance... There's authorized changes. Change your premium with a new table of rates, an increase in your age and so on. Notify you at least 30 days before a change. Can they change this more frequently than once a year? They already say upon implementation of a new table of rates, an increase in your age, or a change in Medicare benefits.

Post-test Interview: Policy B

Q: What is your reaction to this document?

A: You asked me different questions but I think the [policy A] was easier to read, easier to track.

Q: Because of the way it is designed?

A: Yes, and I think they were anticipating the questions more, at least from my point. But this [policy B] looks like the stuff we get. When I was turning—before I turned 65 I got all of this stuff—maybe a dozen insurance companies, including this one. They sent me a big thing of all this stuff and I started looking at it and I decided this was too much. I'm just going to see what the University has to say. They said forget that you're going to be getting a thing from us. But it was, as I recall, difficult thrashing through this.

Q: But as you found the information, you had more questions.

A: Like this increasing the rates question. It doesn't really say the anniversary date or—these are the points in time when we can change the rates. I guess as an engineer I like to see something that is nailed down and they don't surprise me with something. My birth date is December they don't come around in July and say we're raising the rates now because of okay we've got these new tables, so we won't wait until your anniversary date. The table would be tied in with experience with white males and such and such. We've found a new mortality problem or something and therefore we want to change the rates right now. I guess I don't like surprises. I want to know this is when—my house insurance is in November. And I know come November I'm going to have the policy to pay. I don't like surprises. I guess I want to know...this is one, like the house insurance and anniversary. I want to know come November is this premium going to go up.

Q: Any other comments about this—the headings or the bolding?

A: They don't use the bolding, right. [Talking about policy B.] And they've got the highlights for the heading, but then that's it. I think what they've done here—the information is in here but it's not as easy to, if you're in a hurry to find the

information, to pick it out. I guess for my \$184 a month they should do a little more work. Oh, it's even got the Ames office listed on here. Wait a minute, that's gone now. Last fall, I think, it closed. All of our stuff is out of Des Moines. Okay, main office.

## Pre-Test Participant Questions

Name: Alley

Age: 73 y/o

April 6, 2001 at 10:00 a.m.

Q: What are your hobbies?

A: Woodworking.

Q: Are you still out walking a lot?

A: I still walk but not as much without Alley (his dog), I still walk, but that was primarily Alley. I primarily am just helping kids with projects. That's all.

Q: I know that you travel to your children's.

A: Yes, in Colorado and Florida. [Talked about his son in Florida.]

Q: How about reading or playing cards?

A: Read, yes. I read most anything. I like that book Jo gave me to read—*Icebound*. Did you read it? You'll like it. I read and she gave it to me and I thought, you know, I want to read that again. So I went out and bought it. It's very good.

Q: Do you exercise?

A: No, just walking.

Q: Do you do volunteer work?

A: I did do volunteer work at the high school, but since I'm gone to Colorado and Florida all the time.

Q: You said you help the kids with projects, is that woodworking?

A: Oh, anything that had to be done around the property [the high school]. There's always something.

Q: Do you read the newspaper?

A: Yes, the Des Moines paper.

Q: Do you watch TV?

A: Not that much—mainly the news.

Q: Are you a member of and active in any clubs or organizations?

A: No.

Q: What did you do at the Federal Highway Commission?

A: I was a design engineer.

Q: Do you stay connected to engineering at all?

A: Just follow it, but I'm not involved in it.

Q: How about your vision? Any problems with your vision? Do you have cataracts Or anything like that?

A: I have small cataracts. They're growing, I guess. The doctor is following them?

Q: But you don't need large print or have any trouble seeing scores on the TV?

A: Oh, no, not large print. The scores on TV, now if I'm sitting way back here, then that's a problem.

Q: But you don't have glaucoma or macular degeneration or any other problems with your vision?

A: No, maam.

Q: [From earlier and known information: Lives alone. Daughter and grandchildren in Denver, a son in Colorado and a son in Florida. Visits them often. Still drives.]

Q: How would you describe your general health? You look healthy.

A: Good.

Q: No chronic problems?

A: You're probably familiar with it--three years ago I had PMR—polymyalgia rheumatica. And they treated it with Prednisone and then he finally said he wanted to get me off Prednisone and he tapered me off. And he has me on Vioxx. Right now I take it every so often. I was never to where I couldn't do anything I wanted to do. I just felt that sometimes the muscles in my thighs were stiff. Other than that I haven't had anything for years and years and years.

Test #1: Policy B

Questions: D, E, and F

Question D: You want me to find this in here? Shall I use this cover?

Q: If that is what you would normally do.

A: That's not—that's about the policy, that's not going to answer the question. [Talking about information on the front cover after scanning that page briefly. Went to page 1. Does not look at the TOC.] I usually get to the question. Now what am I supposed to do now?

Q: If there is anything in there about the deductible, however you would normally look.

A: You say who pays, you mean...

Q: The deductible—Medicare has a deductible amount that has to be paid before they will start covering. Do you have to pay that deductible or does this policy?

A: I didn't know if that meant did the government reimburse you. I got you. I got you. I would normally scan it like this.

Q: When you scan it, do you look at the headings?

A: Oh, yes, I usually do. [Note: scans pages 2 and 3] Okay, part A is by the insurance company. We pay the part A eligible expenses for hospitalization to the extent not covered by Medicare. [Note: turned to page 4 and read that sentence. This does not concern the deductible amount. Looked down the rest of page 4 and then scanned to page 5.] And we pay the coinsurance amount of Medicare eligible expenses under part B. I think that is right. I have to relate it to my own stuff, but that is right.

Question E: Why do you say "as you know", how do you know that?

Q: It actually says "as you may know." I didn't want to assume that anyone does or does not know that fact. Most people probably don't know that.

A: [Note: starts scanning and reading from where he left off the last question.] The 21<sup>st</sup> to 100 would be by the Medicare supplement insurance.

Q: So for 100 days then?

A: Yes.

Q: So how did you notice that?

A: It says "Nursing Facility Days 21-100 and then I read that.

Q: So the heading caught your eye on that one?

A: Yes, I'm not sure what happens after that 100<sup>th</sup> day.

Question F: [Note: continues scanning from the section he left for the last question. Scans very briefly the pages to the back of the policy and then back to the *Benefits* section on page 3.] What did you do, hide it in here? [Note: appears to read carefully the *Benefits* section.]

Q: Are you still looking at the headings or are you reading more?

A: Reading more. I looked at the headings, but I don't think that it does. It doesn't specifically... maybe it's my conclusion but it says services not honored by Medicare and Medicare doesn't cover it. I concluded that.

Post-test Interview: Policy B

Q: What is your overall reaction to this document? Any parts of it cause you trouble or is it confusing?

A: My first thought is that it is very simplified.

- Q: Do you think too simplified maybe?
- A: Well, maybe if you were hunting specifics. There may be something else that accompanies this. [No, this is the policy that you get.]
- Q: How about the way it is designed? You said you started out by scanning headings, do they seem to pretty well explain what is coming after?
- A: Yes, I think so. See, I guess everybody is going to be different in what their knowledge is and what they would want.
- Q: This document has a table of contents and I noticed that you didn't use that. Are you not a table of contents user?
- A: I just went right past it. I'm the type that puts something together and then goes back and reads the directions. But, no, I use indexes but I didn't, no, I agree. You're very observant, Pat.
- Q: Any other comments about the way it is designed overall? When you found the answer to a question, did it make sense?
- A: Yes, I think so. I guess I'm used to government documents and they specifically spell out eligible and not eligible. I thought there would be something in there talking about preferred providers or whatever. [Yes, this would be quite different from what you are used to. Although a lot of the government documents now are being written in "plain language."]

Test #2: Policy A

Questions: A, B, and C

Question A: [Note: scans the TOC and then through all the pages quickly. Then started over again.]

- Q: Could you read out loud so I know kind of where you are?
- A: [Note: reading headings.] *File a claim.* Health Lines. A..... Insurance. *Health Claim Settlements. Definitions. Benefits to supplement Medicare.* [Note: stops at this section and looks at it for 2-3 seconds.] *Additional Benefits to supplement Medicare.* [Note: looks at this section for 2-3 seconds.] *Exclusions and Limitations.* [Note: scans this section more carefully.] *Payment of claims. General provisions.* I'll start over. I looked at the index that time, but I didn't see it. It didn't jump out at me. [Note: carefully scans page 3 and then goes to page 4.]
- Q: What section are you reading?
- A: *Exclusions and limitations* and I don't even see it. [Note: goes down page 4 and then to page 5. Back to page 4.] Boy, they hid it. [Note: quickly moves through pages again and then back to *Benefits* on page 3.] I don't see it, Pat. [Note:

continues looking on page 4—doesn't seem ready to give up.] Oh, I see they do to. How about that, I went across it but quickly every time. Under additional benefits to supplement Medicare. We will pay for care received in a foreign country as follows: You pay a calendar year deductible of \$250. They pick up 80% of charges for Medicare eligible expenses.

Q: So it does cover?

A: We will pay 80% of billed charges for Medicare eligible expenses. Okay. I was trying to digest there. Medicare isn't paying anything. They will pay 80% of the Medicare eligible expenses. I should have spotted that immediately, you know. Right there on the top line—Emergency care in a foreign country.

Q: Well, it's not bolded or anything. It's does have a lot of bolded words.

A: I know but that should really have told me—additional benefits—it should have. [Note: frustrated that it took him so long to find the answer.]

Question B: [Note: looks straight down the page and notices *Payment of claims.*] Well, they send you a form. You have to give written notice. The doctor files it.

Q: Okay, does it say that?

A: No, it doesn't. It says you must file a claim. We will provide you a form within 15 days. You provide proof of loss information. [So you have to file it?] Yes. Usually Medicare would forward it to them—automatically. It doesn't say that. And I think—you must give us proof, you will meet the proof of loss requirements. [Note: continues reading as though looking for more information on this question.] Is this an actual policy? Well, Medicare will forward it to them. I'm sure. Benefits will be paid to you unless they have been assigned to a doctor. "Unless they have been assigned"—I thought that meant...when you fill out that questionnaire, you say down there you pay the provider or you reimburse them... I don't know.

Question C: [Note: looks on down the same page from last question.] On renewability. This policy is guaranteed renewable for life subject to our right to change rates and subject to you remaining an Iowa resident. Is that right, an Iowa resident? We may also change the rates for this policy form for future renewals. Rates will be based on attained age, sex and rating zone in which you live.

Q: So they can change it?

A: Yes, ma'am, they can change it renewable time, they can change it—that's the only time. I was just reading that and answered my own question about moving to another state. It says that there.



## Post-test Interview: Policy A

- Q: Tell me what you think about this policy. How would you compare the two?
- A: Quite honestly, I think this one is more comprehensive. If I had the choice—while that one (B) is easier to read and it jumps out at you more, if I had my choice I would still take this one. There's more explanation.
- Q: You feel like there is more information?
- A: Yes, even though I couldn't find that one right away...maybe if you weren't sitting there.
- Q: So you like the fact that this one [policy A] has more information, how about the way it is presented? Easy to understand once you find the information?
- A: Yes, I think so. I guess I missed that one on the foreign—I guess I was looking at it because I thought that would be one thing that would be in bold print. Because of the traveling people do today. It is logical that it would be under additional benefits.
- Q: And it is the only thing under that.
- A: It is and I just went across it. I read the emergency care and I thought I'm not talking about emergency care.
- Q: What about the headings? You looked at the table of contents for this one.
- A: Yes, because I thought foreign was going to come out. And then additional benefits—I think I was influenced by my policy where it talks about basic benefits and additional benefits. And I thought additional benefits, I'm not looking for that, I'm looking for foreign.
- Q: What about bolding? They do a lot of bolding, is that helpful?
- A: I don't think so. Some of it. But there's too much.
- Q: The print is smaller and it is condensed more. Was that a problem?
- A: No. If it's in there. I would have found it. There's more information in there.
- Q: You would rather have more information like this [in policy A]?
- A: Yes. There really must be something more than this. Don't they give you rates.
- Q: You would have an application sheet that would probably have rates on it. But it is supplemental to Medicare so it would be subject to their rates.
- A: You know they emphasize [bold] Medicare, I would have thought they would probably be more inclined to emphasize part A and part B rather than the word Medicare.
- Q: They do that more in this one—policy B.
- A: Yes, I didn't say I didn't like that one, Pat, but it just seemed like this one [policy A] was a little more detailed.

Q: So do you like the design of this one [policy A] a little better?

A: They both have pluses I think. That [policy B] definitely has things that jump out at you. I still like the in-depth [of policy A].

Information given before interview: He has supplemental policy provided by government (because he was a government worker). He can change to several options each year and gets a chance to review what each covers. He does not usually look at the policy. The doctor's office has the information.

**APPENDIX B: COPIES OF POLICY A  
AND POLICY B**

**MEDICARE SUPPLEMENT  
PLAN F**

Issued by

**NOTICE TO BUYER:  
THIS POLICY MAY NOT COVER ALL OF  
YOUR MEDICAL EXPENSES**

**INDEX TO YOUR POLICY**

<b>IMPORTANT NOTICES</b> .....	Page 1	<b>EXCLUSIONS AND LIMITATIONS</b> .....	Page 4
<b>HOW TO FILE A CLAIM</b> .....	Page 2	<b>CLAIMS</b> .....	Page 4
<b>AGREEMENT</b> .....	Page 3	Notice of Claim	
<b>DEFINITIONS</b> .....	Page 3	Claim Form	
You, Your		Proof of Loss	
Benefit Period		Time of Payment of Claims	
Eligible Expenses		Payment of Claims	
Medicare		Physical Examinations	
Calendar Year Deductible Amount		<b>GENERAL PROVISIONS</b> .....	Page 5
Reserve Days		Consideration	
Accident		Entire Contract; Changes	
Sickness		Time Limit on Certain Defenses	
Hospital		Grace Period	
Skilled Nursing Facility		Reinstatement	
<b>BENEFITS</b> .....	Page 3	Suspension of Coverage	
Benefits Under Part A of Medicare		Legal Action	
Hospital		Misstatement of Age	
Blood		Conformity With State Statutes	
Skilled Nursing Facility		Periods of Insurance	
Benefits Under Part B of Medicare		Membership, Voting, Annual Meeting	
		Policy Non-Assessable	

This is a legal contract between you and  
**READ YOUR POLICY CAREFULLY**  
**IMPORTANT NOTICES**

**THIS POLICY** is a legal contract between you and us. We agree to pay you benefits for **medicare eligible expenses** which result from accidental injury or sickness based on the policy provisions up to the maximum benefit. These **medicare eligible expenses** must be incurred by you while this policy is in force.

**30 DAY RIGHT TO EXAMINE THE POLICY.** If you return this policy within 30 days after you receive it, we will return your money. Then, it is void as if no policy has been issued.

**RENEWABILITY.** This policy is guaranteed renewable for life subject to our right to change rates and subject to you remaining an Iowa resident. If you change your place of residence, we may issue you a new policy (see page 5). This policy cannot be cancelled or nonrenewed by us on the grounds of deterioration of your health. This policy may be cancelled for nonpayment of premium or material misrepresentation.

**PREMIUM ADJUSTMENT/ATTAINED AGE RATING.** Your renewal premium may be changed if we change the premium for all policies of this form and class in the state where you live. Premiums may also change because of changes in policy benefits resulting from changes in Medicare. In addition to this, your rates will increase yearly, on the first renewal date following your birthday.

### **ABOUT YOUR MEDICARE SUPPLEMENT POLICY**

These pages describe your Medicare Supplement Insurance Policy. It is an explanation of your rights and benefits while you are insured under this policy.

The Benefit Schedule shows the effective date of your insurance and other information which applies to you. The benefits of the policy are explained in greater detail on the following pages.

This policy was designed to provide you with insurance against most of the gaps in Medicare for a sickness or accidental injury. **You have a choice of any licensed physician, surgeon, or any licensed hospital.**

Please read this policy carefully so that you understand the benefits provided.

### **HOW TO FILE A CLAIM WITH**

We certainly hope that you will not encounter a serious sickness or injury. However, if you become sick or injured and file a claim for benefits, here is what to do:

Present your insurance card to the physician, hospital or other service provider.

Ask the provider to send us a copy of your "Medicare Explanation of Benefits" statement they receive from Medicare. If your medical provider does not submit claims to your insurance, simply list your policy number on the "Medicare. Explanation of Benefits" statement and send it to us. Unless we have an authorization to pay those who provided your service, payment will be sent directly to you.

All correspondence with our Home Office should include your policy number (and claim number, if available). Mail to:

### **Health Lines**

If you have any questions concerning any of your insurance needs, please call your American Family Agent who is always pleased to be of service to you.

### **HEALTH CLAIM SETTLEMENTS**

The following information refers to how claims are settled.

This policy limits covered expenses to the usual and customary charge for services. This amount may be less than the billed charge.

If you have questions about the specific methodology that is used to estimate claim payments, you can obtain further information by contacting:

Health Lines Claims Department

## AGREEMENT

**We agree with you**, in return for your premium payment, to insure you:

1. Subject to all the terms of this policy,
2. In reliance upon **your** application which is made a part of this policy.

**We agree to pay you** benefits for **medicare eligible expenses** which result from accidental injury or sickness based upon the policy provisions. These **medicare eligible expenses** must be incurred by **you** while this policy is in force. Payment will be on the same basis for either sickness or accidental injury. Benefits will change automatically to coincide with any changes in **Medicare**.

## DEFINITIONS

As used throughout this policy and shown in bold type:

**YOU, YOUR** means the person shown as named insured in the Benefit Schedule. **WE, US,** and **OUR** mean the American Family Mutual Insurance Company.

**BENEFIT PERIOD.** A **benefit period** starts with the first full day **you** are in a **hospital**. It ends when you have not been in a **hospital** or skilled nursing facility for at least 60 consecutive days.

**MEDICARE ELIGIBLE EXPENSES.** Expenses of the kinds covered by **Medicare**, to the extent recognized as reasonable and customary and medically necessary by Medicare. Any expense or portion of expense that Medicare considers unreasonable, unnecessary or in excess of the Medicare legal limiting charge is not a **medicare eligible expense**.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**CALENDAR YEAR DEDUCTIBLE.** **This is the** amount of **medicare eligible expenses** you must pay each calendar year before benefits can be paid under Part B of Medicare. You need to meet this deductible only once in a calendar year. A calendar year begins on January 1 and ends on December 31.

**RESERVE DAYS.** Sixty additional days of **hospital** benefits which are available under Medicare Part A during **your** lifetime.

**ACCIDENT, ACCIDENTAL INJURY** means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. Injuries shall not include injuries for which benefits are provided or available under any worker's compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless specifically prohibited by law.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. It does not include sicknesses or diseases for which benefits are provided under any worker's compensation, occupational disease, employer's liability or similar law.

**HOSPITAL** means an institution as defined in the **Medicare** program.

**SKILLED NURSING FACILITY** means an institution as defined in the Medicare program.

## SECTION A BENEFITS TO SUPPLEMENT MEDICARE PART A

1. **HOSPITAL CONFINEMENT BENEFITS** - When **Medicare** pays for your stay in a **hospital** we will pay:

- a. your initial deductible for the benefit period;
- b. beginning with the 61st day and continuing through the 90th day of confinement, all other **medicare eligible expenses** under Medicare Part A not paid by Medicare;
- c. beginning with the 91st day, all other **medicare eligible expenses** under Medicare Part A not paid by Medicare for each day of confinement until your **reserve days** under Medicare have been used up;
- d. beginning with the 151st day or the first day following the exhaustion of the reserve days or the maximum coverage for inpatient psychiatric care,

whichever occurs first, all other **medicare eligible expenses** under Medicare Part A not paid by Medicare. We will not pay more than 365 days of such hospitalization in **your** lifetime.

2. **BLOOD TRANSFUSION EXPENSE BENEFIT** - If you are charged a nonreplacement fee for a blood transfusion during a **hospital** or **skilled nursing facility** confinement, we will pay this fee for the first three pints of blood in a benefit period.

3. **SKILLED NURSING FACILITY CARE** - We will pay the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a benefit period for posthospital skilled **nursing facility** care eligible under Medicare Part A.

## SECTION B BENEFITS TO SUPPLEMENT MEDICARE PART B

Benefits are payable as follows:

1. When **Medicare** pays for Part B services and supplies, we will:

- a. Pay the **calendar year deductible**, and
- b. Pay 20% of your **medicare eligible expenses** incurred for those **Medicare** Part B services and supplies, and
- c. Pay 100% of the difference between the actual billed amount for those incurred **Medicare** Part B

services and supplies (not to exceed any charge limitation established by the **Medicare** program or a state law) and the Part B **medicare eligible expenses**.

2. If **you** are charged a nonreplacement fee for a blood transfusion, **we** will pay this fee for the first three pints of blood in a calendar year.

If **you** are not enrolled in Part B of **Medicare**, we will pay benefits as if **you** were enrolled.

## SECTION C ADDITIONAL BENEFITS TO SUPPLEMENT MEDICARE

1. Emergency Care in a Foreign Country  
**We** will pay for care received in a foreign country as follows:

- a. First **you** pay a calendar year deductible of \$250, then
- b. **We** will pay 80% of billed charges for **Medicare eligible expenses** for medically necessary **emergency care** (hospital, physician and medical) received in a foreign country which care would have been covered by Medicare if provided in the United States, and

- c. Which care began during the first 60 consecutive days of each trip outside the United States, subject to
- d. A lifetime maximum of \$50,000.

For this benefit, the additional definition applies:

**EMERGENCY CARE** means care needed immediately because of an injury or an illness of sudden and unexpected onset,

## EXCLUSIONS AND LIMITATIONS

**EXPENSES NOT COVERED BY THIS POLICY.** No benefits are provided for:

1. The daily co-payment amount under **Medicare** Part A for **skilled nursing care** above the number of days covered by **Medicare**.
2. **Medicare eligible expenses** incurred while your policy is not in force.
3. Any expense or portion of expense not covered by **Medicare** except as noted in the benefits section of this policy.
4. Outpatient treatment for mental illness beyond what **Medicare** pays.
5. Private duty nursing.
6. Custodial or intermediate nursing care.
7. Self-administered drugs or biologicals.
8. Charges for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.
9. Expenses for routine physical examinations and directly related tests, eye glasses or eye examinations for the purpose of prescribing, fitting or changing eye glasses, or hearing aids.

10. Charges for cosmetic surgery, except if required for the prompt repair of accidental injury and for the improvement of the functioning of a malformed part of the body.
11. Charges for routine foot care, orthopedic shoes or supportive devices of the feet.
12. Charges which neither **you** nor another party on **your** behalf has a legal obligation to pay.
13. Charges paid directly or indirectly by any governmental agency.
14. War or any act of war.
15. Personal comfort items.
16. People not covered by **Medicare** Part A and Part B.
17. Payment that has been made, or can reasonably be expected to be made, under a worker's compensation law or plan of the United States or a state.
18. Charges imposed by **your** immediate relatives or members of **your** household.
19. Home health care above the number of visits covered by **Medicare**.

**We** will not duplicate any benefits paid by Medicare.

## PAYMENT OF CLAIMS

On all claims matters, contact \_\_\_\_\_ company,

**NOTICE OF CLAIM.** **You** must give **us** written notice of a claim. The notice must identify **you** and **your** policy number.

**CLAIM FORM.** When **we** receive the notice of claim, **we** will send **you** forms for filing proof of loss. If these forms are not given to **you** within 15 days, **you** will meet the proof of loss requirements by giving **us** a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

**PROOF OF LOSS.** You must give us, at our Home Office, written proof of loss. This proof must be received within 90 days after the loss. Proof of Loss shall include written proof of payment made by Medicare. If you fail to give proof within the time required, this will not make the claim invalid. However, it must not have been reasonably possible to give proof within the required time. The proof must be given as soon as reasonably possible. In no event, except in the absence of legal capacity, may proof be given later than 15 months after the loss.

**TIME OF PAYMENT OF CLAIMS.** Benefits will be paid promptly upon receipt of Proof of Loss.

**PAYMENT OF CLAIMS.** Benefits will be paid to **you** unless they have been assigned to a doctor, hospital or other provider. Any benefits unpaid at your death will be paid to the beneficiary you have designated or to **your** estate.

**PHYSICAL EXAMINATIONS.** We, at our own expense, have the right to have you examined as often as reasonably necessary while a claim is pending.

## GENERAL PROVISIONS

**CONSIDERATION.** This policy is issued on the basis of the statements and agreements in the application. Premium payment in advance will keep this policy in force from the Policy Effective Date until the First Renewal Date. The premium is set out in the Benefit Schedule. Each renewal premium is due on its due date subject to the grace period.

**ENTIRE CONTACT; CHANGES.** This policy, a copy of the application, benefits schedule and any endorsements and riders, are the entire contract. It may not be changed unless approved by one of our officers. That approval must be shown in this contract. No agent may change or waive any of the contract's provisions.

**TIME LIMIT ON CERTAIN DEFENSES.** After this policy has been in force for two years, no misstatements made by you in the application will be used to void the policy.

**GRACE PERIOD.** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

**REINSTATEMENT.** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by **us** (or by an agent authorized to accept payment) prior to the 60th day following the due date will reinstate this policy.

The reinstated policy will cover loss that results from an injury or sickness sustained after the date of reinstatement. In all other respects, your rights and ours will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Any premium accepted in connection with a reinstatement, will be used to pay back premiums due. But no policy may be reinstated after the 60th day following the due date.

**RENEWABILITY.** This policy is guaranteed renewable for life subject to our right to change rates and subject to you remaining an Iowa resident. Renewal requires payment of premiums when due at the rates effective at renewal dates. **We** may also change the rates for this policy form for future renewals. Rates will be based on attained age, sex and rating zone in which you live.

If **your** residence is no longer Iowa and **you** move to a state in which **we** are not licensed to sell Medicare Supplement insurance, **you** will keep this policy. If **your** residence is no longer Iowa and you move to a state in which **we** are licensed to sell Medicare Supplement insurance, **you** will be issued a new policy providing coverage as similar to the coverage of this policy as is then being issued by American Family Insurance Company and its subsidiaries for the new state. When eligible expenses are incurred prior to the address change, the policy in force at the time the eligible expenses are incurred will apply. **We** do not have the right, except as stated above, to refuse to renew your policy.

**SUSPENSION OF COVERAGE.** If **you** become eligible for medical assistance under Title XIX of the Social Security Act, **your** policy benefits and premiums shall be suspended for a maximum of 24 months from the date **you** are entitled to this assistance. You must notify **us** within 90 days of your eligibility for this to apply.

If you lose medical assistance entitlement, the policy will be automatically reinstituted effective the date of termination, provided, that **you** notify **us** of this change within 90 days of your termination date.

Upon reinstitution of coverage, no new waiting periods will apply to pre-existing conditions. **Your** policy coverages will be the same as were in effect prior to suspension. The premium charged is the same as would have been charged if the policy was not suspended.

**LEGAL ACTION.** You cannot bring a legal action against **us** until 60 days after written proof of loss has been given to **us**. No action can be brought after three years from the time that proof is required to be given.

**MISSTATEMENT OF AGE.** All amounts payable will be reduced in proportion to the amount by which the premium was underpaid.

**CONFORMITY WITH STATE STATUTES.** If this policy, on its effective date, is in conflict with the state laws where you live, it is changed to meet the minimum requirements of those laws.

**PERIODS OF INSURANCE.** All periods of insurance begin and end at 12:01 AM., Standard Time at **your** residence.



**MEMBERSHIP, VOTING, ANNUAL MEETING AND PARTICIPATION.** You are a member of the Company

and are entitled to one vote either in person or by proxy at its meetings. The Annual Meetings are held at its Home Office on the first Tuesday of March at 2:00 P.M. Printed notice in this policy shall be sufficient as to notification.

If any dividends are distributed, you will share in them according to law and under conditions set by the Board of Directors.

**POLICY NON-ASSESSABLE.** This policy is non-assessable. You are not subject to any assessment beyond the premiums we require for each policy period.

This policy is signed at \_\_\_\_\_ on our behalf by our President and Secretary. If it is required by law, it is countersigned on the Benefit Schedule by an authorized representative.

**President**

**Secretary**

**This is not a Complete and valid contract without an accompanying Benefit Schedule properly executed.**

## SENIOR

### Medicare Supplement Plan F

**Right to Return**

You have the right to return this policy to us within 30 days of its receipt and to have your premium payment refunded if, after examination, you are not satisfied for any reason. If we have paid claims for you during this inspection period, we have the right to recover any amounts we paid.

**Policy Term and Renewal**

This policy is in force for one month from the effective date. This policy is automatically renewed each month with your advance premium payment unless it is terminated by you or by us. We may change the premium from time to time, but only if we change the premium for all policies like yours issued in this State. When we change the premium upon our implementation of a new table of rates or a change in Medicare's benefit structure, your new premium will be based upon your age at the effective date of the premium change. If we do change your premium, we will notify you at least 30 days in advance. Since benefits are tied to Medicare's deductible and coinsurance amounts, premium and benefit changes are expected to occur each January.

**Notice to Buyer**

This policy may not cover all of your medical expenses.

In exchange for your completed application, payment of the first premium as shown on your application, and your payment of renewal premiums when due, we will pay the benefits of this policy according to its provisions.

President

Secretary

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## IMPORTANT INFORMATION

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**Y**our Medicare supplement health care coverage is called **Plan F**. This product was developed to help you pay for some of your health care expenses not paid in full by Medicare. *This coverage only pays for those services accepted and approved by Medicare with the exception of benefits for medically necessary emergency care outside the United States.*

To understand your benefits, you must first understand your Medicare benefits. Therefore, it is very important that you also read *Your Medicare Handbook* carefully. If you do not have a Medicare Handbook, you may order one by calling your Social Security office.

Medicare benefits are divided into two categories: Medicare Part A and Medicare Part B.

### ■ Medicare Part A

Medicare Part A helps pay for inpatient hospital care, skilled care in a nursing facility, home health care, and hospice services. We offer you supplemental benefits in all of these categories except for hospice.

### ■ Medicare Part B

Medicare Part B helps pay for physician services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Medicare Part A. We offer you supplemental benefits in all these

categories as stated in the BENEFITS section, with the addition of benefits for medically necessary emergency care outside the United States.

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## THE WAY PAYMENT WORKS

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When a physician or supplier agrees to accept the charge approved by Medicare as the most he or she will collect for covered services, he or she is said to accept *assignment*. All physicians who participate in the Medicare program agree to accept assignment. If you are not sure if your physicians participate in the Medicare program, ask them and they will tell you.

If a physician does not accept assignment, he or she may collect more than Medicare's approved amount. When this happens, we will pay this difference for you.

If your provider accepts assignment, we will send our payment directly to that provider. If your provider does not accept assignment, we send our payments to you, or, in the event of your death, to your estate.

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## FILING CLAIMS

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You do not need to file a claim with Medicare for any services. By law, physicians or other suppliers must fill out claim forms for you and send them to Medicare even if they do not accept assignment.

You should always make sure your providers know that you have

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**IMPORTANT INFORMATION**

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supplemental coverage with us. When you receive health services in your home state, Medicare will automatically send your claim to us.

■ **Out-of-State Services**

If you receive health services outside of your home state, the provider will submit your claim to the Medicare office in that state. After the office processes the claim, you will receive an Explanation of Medicare Benefits (EOMB). If the *Notes* section of the EOMB says that the information is being sent to your private insurer, we will automatically receive the EOMB.

If the EOMB does not say your private insurer is receiving the information, you need to send the EOMB to us so we can process your Medicare supplement benefits. Be sure your identification number and mailing address are shown accurately on the EOMB form. You do not need to complete a claim form. Just send the EOMB, and keep a copy for your own records. Send it to:

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**BENEFITS**


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**M**edicare Part A helps pay for most but not all of the services you receive in a hospital or nursing facility or from a home health agency or hospice program. Medicare Part B helps pay for some but not all doctor services and other medical services and supplies that are not covered under Medicare Part A. Your coverage with us helps pay for some of the remaining health care expenses.

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**BENEFIT PERIOD**


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A benefit period under Medicare Part A is used to count the number of days you are covered for medically necessary services in a hospital or other facility primarily providing skilled or rehabilitation services.

There is a limit on how many days of hospital or nursing facility care Medicare helps pay for in each benefit period. However, it is possible to renew a benefit period. When your benefit period is renewed, your Part A protection is also renewed. Renewing a benefit period means that you begin a new benefit period.

During a benefit period, Medicare will help you pay for medically necessary covered services when you are an inpatient in a hospital for 90 days. If you are in the hospital for more than 90 days, then Medicare offers 60 lifetime reserve days you can use to help meet expenses.

■ **When Benefit Periods Begin and End**

A benefit period begins on the first day you enter a hospital or nursing facility as an inpatient.

A benefit period ends after you have been out of the facility for 60 days in a row (including the day of discharge).

A benefit period starts over when you reenter a hospital or nursing facility more than 60 days after your last discharge.

The following are two examples of how the benefit period works. The first example shows when the benefit period is renewed. The second example shows when the benefit period is not renewed.

## BENEFITS

### Example 1

#### *Benefit period is renewed.*

Let's say you enter the hospital on January 15. You are discharged on January 25. You use 10 days of your first benefit period. You are not hospitalized again until July 20.

Since more than 60 days passed between your hospital stays, you begin a new benefit period. This means your Medicare Part A coverage is completely renewed. Therefore, you have 90 eligible days to use in the new benefit period.

### Example 2

#### *Benefit period is not renewed.*

Let's say you enter the hospital January 15. You are discharged January 25. As before, you use 10 days of your first benefit period. However, you are then re-admitted to the hospital on February 20.

Since less than 60 days passed between hospital stays, your benefit period is not renewed. You are still in your first benefit period. The first day of your second admission (February 20) is counted as day 11 of hospital care in that benefit period. Therefore, you have 80 remaining eligible days in that benefit period. You will not begin a new benefit period until you have been out of the hospital (or nursing facility) for 60 consecutive days.

## MEDICARE PART A COINSURANCE

We will help pay for some of the expenses while you are in the hospital by supplementing Medicare's coverage.

### ■ Days 61-90

We pay the Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

### ■ Days 91-150

We pay the Part A eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day you use. (See *Your Medicare Handbook* for an explanation of reserve days.)

### ■ Additional Days

Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, we pay the Part A eligible expenses for hospitalization at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

## MEDICARE BLOOD DEDUCTIBLE

We pay, under Medicare Parts A and B, for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.



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**BENEFITS**


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**MEDICARE PART B COINSURANCE**


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We pay the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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**MEDICARE PART A DEDUCTIBLE**


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We pay all of the Medicare Part A inpatient hospital deductible amount per benefit period.

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**NURSING FACILITY DAYS 21-100**


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We pay for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

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**MEDICARE PART B DEDUCTIBLE**


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We pay all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

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**ONE HUNDRED PERCENT (100%) OF MEDICARE PART B EXCESS CHARGES**


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We pay all of the difference between the actual Medicare Part B charge as billed—not to exceed any charge limitation established by the Medicare program or state law—and the Medicare-approved Part B charge.

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**MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**


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To the extent not covered by Medicare, we pay for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, subject to a calendar year deductible of two hundred fifty dollars (\$250) and a lifetime maximum benefit of fifty thousand dollars (\$50,000). The emergency care must have been eligible for coverage by Medicare if provided in the United States, and the care must have begun during the first sixty (60) consecutive days of each trip outside the United States. For purposes of this benefit, *emergency care* means care needed immediately because of an injury or an illness of sudden and unexpected onset.

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**SERVICES NOT COVERED**

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- W**e will not allow benefits for:
- services not allowed by Medicare as benefits, except as stated in the **BENEFITS** section of this policy;
  - services denied by Medicare, except as stated in the **BENEFITS** section of this policy; and
  - services that would duplicate benefits provided by Medicare.
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If you have any questions after reading *Your Medicare Handbook* and this Senior Blue policy, please call us or seek help from a service center nearest you. Our toll-free number and regional office addresses are listed on the back cover of this policy. Remember, we're here to help you.

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## YOUR POLICY

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**O**ur responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your contract. Your contract includes:

- the application for coverage
- this benefits policy
- any riders or amendments.

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### WHEN COVERAGE BEGINS

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Once we receive your application and premium, your policy goes into effect for one month. If your premium is paid on time and your policy is not terminated by you or us, we will automatically renew your policy each month.

Before you receive benefits under this policy, you must agree to release any necessary information requested about you so we can process claims for benefits. Since we will not physically examine you to determine your eligibility for benefits under this policy, you must allow any provider, facility or their employee to give us information about a treatment or condition. If we do not receive requested information, or if you withhold information in your application, your benefits may be denied.

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### PREMIUMS

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You must pay us in advance each calendar month for the duration of your contract. The payment must meet the premium requirements for that month.

- A grace period of 31 days will be granted for the payment of each premium due after the first premium. During this grace period, the policy will continue in force.

- If you fail to pay any monthly renewal premium within the 31-day grace period, your coverage will lapse. You may request reinstatement of this policy by submitting an application for reinstatement to us. We will give you written notice of our decision on your application for reinstatement. If we do not notify you of our disapproval within 45 days of the date you submitted your application for reinstatement, this policy will be reinstated upon the 45th day following our receipt of your application for reinstatement. If reinstated, this policy will only cover claims that occurred after the date of reinstatement.

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### AUTHORIZED POLICY CHANGES

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No agent, employee or representative of ours is authorized to vary, add to, change, modify, waive or alter any of the provisions of this policy. This policy cannot be changed except by written amendment signed by one of our authorized officers and accepted by you as shown by payment of the monthly premium.

Your acceptance of an amendment must be in writing if the amendment:

- Reduces or eliminates benefits; or
- Increases benefits with an increase in premium during the policy term,

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## YOUR POLICY

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unless the increase in benefits is required by law.

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### MEDICARE DEDUCTIBLE AND COINSURANCE CHANGES

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The deductible and coinsurance amounts to be paid by us will automatically change when Medicare's deductible and coinsurance change. This usually happens on January 1 each year.

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### PREMIUM CHANGES

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We have the right to change your premium upon our implementation of a new table of rates, an increase in your age, or a change in Medicare's benefits. If we do change your premium, we will notify you at least 30 days before the change.

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### WHEN COVERAGE ENDS

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Your coverage will end immediately if any of the following occurs:

- You fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premium paid.
- You fail to pay your monthly premium by the end of the grace period.
- You terminate this policy by giving written notice of termination to
  - at least 30 days before the termination date.

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### EFFECTS OF TERMINATION

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If your policy is terminated for misrepresentation or the concealment of material facts:

- We will not pay for any services or supplies provided after the date the policy is terminated.
- We will retain legal rights, including the right to sue based on concealment or misrepresentation.
- We may, at our option, declare the policy void.

If your policy is terminated for reasons other than concealment or misrepresentation of material facts, we may stop payment for any services or supplies the day your policy is terminated.

An exception to this applies in the case of a continuous loss that commenced while this policy is in force. If you receive covered professional or facility services as an inpatient of a hospital or nursing facility on the date this policy terminates, payment for these covered services will end on the earliest of the following:

- The date you are first discharged from the facility following termination of this policy;
- The date the policy coverage period would have ended if this policy had not been terminated—that is, the end of the calendar year during which you were an inpatient;

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**YOUR POLICY**


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- The date your Medicare benefits are exhausted if no additional benefits would otherwise have been covered under this policy had it remained in effect; or

- Payment of maximum benefits.

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**SUSPENSION OF COVERAGE AVAILABLE DURING MEDICAID ELIGIBILITY**


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You may request a suspension of coverage for the period (not to exceed twenty-four (24) months) in which you have applied for and have been determined entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). You must notify us within ninety (90) days after the date you become entitled to such assistance. We shall return to you that portion of the premium you paid which is attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If a suspension occurs and you lose entitlement to Medicaid assistance within twenty-four (24) months, your policy will be reinstated automatically as of the date your entitlement is terminated if you notify us that you lost Medicaid entitlement. You must notify us within ninety (90) days after the date of such loss, and you must pay the premium attributable to the period, effective as of the date of termination of Medicaid entitlement.

Reinstatement of coverage:

- Will not provide for any waiting period with respect to treatment of pre-

existing conditions;

- Will provide coverage substantially equivalent to the coverage in effect before the date of suspension; and

- Will provide for premium classification on terms at least as favorable to you as the premium classification terms that would have applied had the coverage not been suspended.

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**OUR RIGHT TO RECOVER PAYMENTS**


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If for any reason we make payment under this policy in error, we may recover the amount we paid.

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**NOTICE**


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If a specific address has not been provided elsewhere in this policy, it is sufficient to address and send any notice to our home office:

Any notice from us is acceptable when sent to your address as it appears on our records.

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**LEGAL ACTION**


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No legal or equitable action may be brought against us because of a claim under this policy, or because of the alleged breach of this policy sooner than

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## **YOUR POLICY**

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60 days from the filing of a claim and not more than two years after the end of the calendar year in which the health care services or supplies were provided.

excluded from coverage by name or specific description effective on the date of service had existed prior to the effective date of coverage of this policy.

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## **NONASSIGNMENT**

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Benefits for covered services in this policy are for your personal benefit and cannot be transferred or assigned to anyone else. Any attempt to assign this policy or rights to payment will be void.

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## **GOVERNING LAW**

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To the extent not superseded by the laws of the United States, this policy will be construed in accordance with and governed by the laws of the state of Iowa. Any action brought because of a claim under this policy will be litigated in the state or federal courts located in the state of Iowa and in no other.

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## **TIME LIMIT ON CERTAIN DEFENSES**

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After two years from the effective date of this policy, no misstatements, except fraudulent misstatements, made by you in the application for this policy can be used to void your policy or deny a claim for an illness or injury incurred commencing after the expiration of the two-year period.

No claim for illness or injury commencing after two years from the effective date of this policy will be reduced or denied on the grounds that the disease or physical condition not

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**GLOSSARY**


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**Assignment** means a provider or supplier agrees to accept Medicare's approved charge as full payment for a service or supply. This does not include any deductible or coinsurance amount you are responsible for paying.

**Coinsurance** is the percentage of expenses you pay for covered services.

**Contract** means all of the following:

- your application for coverage;
- this benefits policy; and
- any riders or amendments.

**Covered Services** means medically necessary, Medicare-approved services and supplies that qualify for payment of benefits under this policy.

**Deductible** is an initial amount you must pay before Medicare or we will begin paying for services.

**Emergency Care** is care that is needed immediately because of an injury or an illness of sudden and unexpected onset.

**Explanation of Medicare Benefits (EOMB)** is a form summarizing the action Medicare took on your claim and what amount, if any, Medicare paid for the services you received.

**Hospital** means a facility that provides for the diagnosis, treatment or care of injured or sick persons. The facility must be licensed as a hospital under applicable law.

**Illness or Injury** means a bodily disorder, bodily injury, disease, or mental illness. We will not provide

benefits if your illness or injury falls under:

- motor vehicle no-fault plan;
- workers' compensation; or
- employers' liability or similar law, unless prohibited by law. This includes any injury you receive while you were working or while engaged in any activity pertaining to any trade, business, employment or occupation for wage or profit.

**Medicare** is the Health Insurance for the Aged Act, Title XVIII of the Social Security Act.

**Medicare Benefit Period** counts the number of days under Medicare Part A that you are covered for medically necessary services in a hospital or other facility primarily providing skilled or rehabilitation services. The benefit period begins on the first day you receive inpatient hospital services for which Medicare Part A allows benefits. The benefit period ends after you have been out of the hospital or nursing facility for 60 consecutive days.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

**Nursing Facility** provides continuous skilled nursing services as ordered and certified by your attending physician. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. A nursing facility must also be licensed under applicable law.

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**GLOSSARY**

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**Our means**

**Physician** means a doctor of medicine (MD); doctor of osteopathy (DO); chiropractor; doctor of podiatric medicine (podiatrist); doctor of dental surgery or dental medicine (dentist); or doctor of optometry (optometrist).

**Plan Member** means you, the person who signed for this policy.

**Policy Coverage Period** is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. This is true for as long as you have coverage.

**Provider** means any licensed or approved health care professional, including a physician, psychologist (who has a doctorate degree in psychology with two years' clinical experience or who meets the standards of a national register), chiropractor, optometrist, podiatrist, physical therapist, oral surgeon, certified registered nurse anesthetist, or any other provider approved by Medicare.

**Us means**

**We means**

**You and Your** means the plan member.



**APPENDIX C: HUMAN SUBJECTS APPROVAL  
AND CONSENT FORM**

## Iowa State University Human Subjects Review Form

OFFICE USE ONLY		
EXPEDITED _____	FULL COMMITTEE _____	ID# <u>01401</u>

PI Name Patricia A. Allen Title Graduate Student

## Checklist for Attachments

The following are attached (please check):

13. ☒ Letter or written statement to subjects indicating clearly:
- a) the purpose of the research
  - b) the use of any identifier codes (names, #'s), how they will be used, and when they will be removed (see item 18)
  - c) an estimate of time needed for participation in the research
  - d) if applicable, the location of the research activity
  - e) how you will ensure confidentiality
  - f) in a longitudinal study, when and how you will contact subjects later
  - g) that participation is voluntary; nonparticipation will not affect evaluations of the subject
14. ☐ A copy of the consent form (if applicable)
15. ☐ Letter of approval for research from cooperating organizations or institutions (if applicable)
16. ☐ Data-gathering instruments

17. Anticipated dates for contact with subjects:

First contact

March 1, 2001  
Month/Day/Year

Last contact

March 30, 2001  
Month/Day/Year

18. If applicable: anticipated date that identifiers will be removed from completed survey instruments and/or audio or visual tapes will be erased:

The convention of our discipline expects that we retain data rather than erase or destroy it. The confidentiality of the data is, of course, protected.

Month/Day/Year

19. Signature of Departmental Executive Officer

Date

Department or Administrative Unit

Charles J. Hittchard2/12/01English

20. Initial action by the Institutional Review Board (IRB):

☐ Project approved☐ Pending Further Review☐ Project not approved

Date

Date

☐ No action required

Date

21. Follow-up action by the IRB:

Project approved

3-1-01

Project not approved

Date

Project not resubmitted

Date

Patricia M. Keith

Name of IRB Chairperson

3-1-01  
Approval DatePatricia M. Keith  
Signature of IRB Chairperson

## Consent Form

Please read this document and ask any questions you may have before agreeing to be in this study.

I am an Iowa State University graduate student completing my master's degree in technical writing. I have been studying some documents to see how they are written, and I'm trying to determine what is good and what is not so good about the way these documents are written and designed. I am interested in documents that are written primarily for people over the age of 65. I am looking specifically at insurance policies. I am not doing this work for the insurance companies; I am doing it strictly for my thesis project.

Here is my plan: I will give you a specific problem or situation that you could resolve by looking for information in the policy. I have two different policies that are written and designed differently. So I would give you situations for the first policy and then different problems or situations for the second policy. This is not a test of you, but your test of the documents. If you are unable to find the answer or solution within what you consider a reasonable amount of time, then please just say that the information cannot be found.

In order for me to find out which parts of the policies are good and which are not so good, I need to have you think out loud and read out loud as you look for information. Please just say whatever you are thinking. I will tape record you so that I can then study the policies and your comments about them, which will help me to understand where, if any, the problems are and to understand how the policies might be changed.

You do not need to give your name on tape. I will ask you to select a code name for yourself and the code name is the only name that will be used throughout my project. I would also like to find out a little bit about you, such as are you retired, what kind of work are you or did you do, what kinds of activities you like to do and that kind of thing. After each document is tested, I will ask you some general questions about that document.

The tests should take about 30 minutes. If you decide to participate, you are free to withdraw at any time. You may ask any questions you have now or contact me later at (515) 232-7904. You will be given a copy of this form to keep.

### Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

_____	Date _____
Participant	
_____	Date _____
Investigator	

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